CARING FOR PROFIT

The Commercialization of Human Services in Ontario

OCTOBER, 1984

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of Metropolitan Toronto

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CARING FOR PROFIT: THE COMMERCIALIZATION OF HUMAN SERVICES IN ONTARIO

SUMMARY AND RECOMMENDATIONS

Cntario is drifting toward greater reliance on the commercial sector for the provision of human services. Commercialization, the trend to for-profit service provision, is already apparent in a number of service fields, such as nursing homes, rest homes, children's residences and day care centres and, more recently, in hospital management and home support services.

For-profit service provision should be examined within the broader context of "privatization", the movement to shift responsibility for human services from the public to the private sector. Although commercialization is only one strategy for achieving privatization, it warrants special attention because of its relative newness and its potential for serious and far-reaching consequences.

Experiences from other jurisdictions suggest that there are substantial risks associated with expanding the role of the commercial sector. Yet, the Ontario government has no overall policy on commercialization of human services. The purpose of this paper is to explore the practical and philosophical issues which must be taken into account in future policy development. Specifically, commercialization is assessed in relation to its effects on: accountability to service users and to government; influence on public policy; quality of service; equity (equality of access and of treatment); and cost-effectiveness.

The Push for Privatization: Arguments For and Against

Privatization in both Canada and the United States has been given a push by the government's desire to curb public spending, a perceived loss of trust in government, and the increased demand for services by people who look to the marketplace for satisfaction of their needs. Fundamental to the

case for privatization is the challenge of the government's role and legitimacy in social welfare. The proponents of privatization oppose anything other than a residual government role in human services. Such a view is in stark contrast with the position that the government should ensure that all people are guaranteed a decent standard of living as a matter of right.

The advocates of privatization promote the following strategies: increasing marketplace competition in human services; eliminating universal programs which benefit all people in favour of more selective ones; shifting the burden of costs from the tax-supported public system to the private sector and private individuals; and expanding the role of the commercial sector in the provision of human services. The profit motive, it is argued, acts as an incentive to efficiency, cost-reduction, flexibility and effective performance. The critics, by contrast, maintain that for-profit service provision results in a lower quality of service, unequal access, lack of accountability and responsiveness, and the danger that public policy will be defined by corporate interests.

The Commercialization of Human Services in Ontario

In the early 1970's, the Ontario government began to lean toward privatization, including the use of the commercial sector to provide human services. In the absence of a provincial government policy on commercialization, Ontario's drift to for-profit service provision has been proceeding by both design and default. In spite of apparent inconsistencies between the Ministries of Health and Community and Social Services, the commercial sector's role in Ontario's human services is substantial, as indicated by the following 1983 statistics:

- Over 90 percent of the province's 332 nursing homes were operated for profit;
- Over half of Ontario's beds for elderly people were provided for profit, compared with 27 percent in the rest of Canada;
- Almost half of Ontario's 70,000 licensed day care spaces were in the commercial sector;

- o One out of every three residential beds for children in Ontario was provided for profit, compared with one out of ten in the rest of Canada;
- o Half of the contracts for homemaking services purchased by Ontario's local Home Care Programs were with commercial agencies;
- o The more than 6,300 people in the Homes for Special Care Program were in for-profit nursing or residential homes;
- o Most of Ontario's estimated 450 rest homes/retirement homes were commercial enterprises;
- o For-profit corporations began to manage public hospitals in Ontario.

A major impetus for the emergence of human services for profit is the program and policy vacuum being created by increasing government withdrawal from service delivery and/or funding. The area of greatest potential growth for Ontario's commercial sector is in health care - the most profitable and capital intensive human service. As evidenced in the United States, the prospect of government spending restraint acts as a clear incentive for increased private sector involvement, particularly in health care.

Lessons from the American Experience

In the United States, commercialization is more pronounced and long-lived than in any other jurisdiction. Hospitals, prisons, nursing homes, home support services, day care centres , and group homes for children are provided by for-profit operators whose primary clientele generally are people with ability to pay.

In the hospital, nursing home, and day care industries, a major issue has been the influence on public policy exerted by the large corporations. The commercial sector's anti-regulatory activities and attempts to monopolize the market have made accountability to service users and to government extremely difficult to ensure.

Although lower costs and greater efficiency are frequently claimed

to be the primary benefits of commercial service provision, the supporting evidence is far from conclusive. Recent studies showed that costs were higher in for-profit hospitals than in their non-profit counterparts. In the for-profit nursing homes, lower costs are frequently achieved at the expense of service quality and staff salaries. Similarly, commercial day care centres are able to keep operating costs down by sacrificing services, staff/child ratios, and workers' salaries. Although commercial operators sometimes profess to provide better services than their non-profit and public counterparts, there is evidence to suggest that quality of care suffers in some for-profit services.

The expansion of the commercial sector has contributed to the emergence of a two-tiered system of health care. Equality of access and treatment has been threatened by the for-profit hospitals' practice of selecting only the most profitable patients. The burden of caring for people unable to pay is increasingly falling on the non-profit and public hospitals.

Issues and Implications for Ontario

Problems with for-profit service provision similar to those experienced in the United States are becoming evident in Ontario. Lack of accountability to service users and to government is most pronounced in the nursing home industry where there is virtually no competition among owners, limited alternatives to nursing home care, and a consistently high demand for beds. Although the Ministry of Health has made some efforts to increase accountability, serious problems remain.

In the rest home/retirement home and boarding home industries, the accountability problems associated with commercial service provision are exacerbated by the absence of provincial regulation. A major issue in commercial day care is the lack of parent involvement in the operation of the centre.

Ensuring accountability to government has been particularly elusive for the Ministry of Community and Social Services (COMSOC) because of the

heavy reliance on contracting with non-governmental organizations. The Ministry keeps no central record of how many and which children's residences are operated for profit and cannot estimate how much provincial money is spent to subsidize commercial services. This lack of information raises questions about COMSOC's ability to monitor adequately the service system for which it is ultimately responsible.

A 1984 task force report prepared for the Canadian Medical Association called for the elimination of 'care for profit' institutions because of concerns over quality of care in nursing homes. In view of recent coroner's inquests into the deaths of nursing home residents and numerous reports of violations of the Nursing Homes Act in Ontario, such concerns appear to be justified.

Although there are no studies comparing quality of care in commercial and non-profit day care centres, many experts from the day care community agree that quality is generally better in the non-profit centres. The commercial sector's opposition to improved standards and anecdotal evidence of cost-cutting measures which negatively affect quality have helped to reinforce this view.

The commercial sector is sometimes acclaimed for its ability to respond quickly to identified demand. Although there is evidence that some for-profit organizations are more flexible than many voluntary agencies, it appears that this flexibility is achieved at the expense of staff salaries and questionable labour practices.

There are indications that equity, or equality of access, may be threatened by for-profit service provision. It is widely held that nursing homes are reluctant to accept patients who require heavy care. The imposition of additional charges and the practice of encouraging patients to hire "private nurses" to supplement the care provided in the homes create further financial barriers to access.

Conclusion and Recommendations

The available evidence we have gathered from Ontario and the United States raises major questions about the drift toward human services for profit, particularly in light of the fact that the provincial government has no coherent, overall policy on commercialization. The situation is serious enough for us to recommend that the provincial government take immediate action on the issues identified in this report.

To the Government of Ontario, we recommend:

1. That there be a moratorium on commercialization of human services in Ontario until an appropriate review has been undertaken. This moratorium would entail:

   - o no new licensing or funding of commercial operations;
   - o no further approval of experiments in hospital management by for-profit firms;
   - o no decisions to allow the commercial sector to enter new service fields (e.g. prisons); and
   - o no legislative or policy shifts which may result in the expansion of the commercial sector (e.g. retain present statutory restrictions on for-profit service provision when enacting Bill 77, the Child and Family Services Act).

2. That the Standing Committee on Social Development of the Ontario Legislature immediately undertake a policy review of commercialization in Ontario which would include answers to the following questions:

   - o How should commercial service provision be defined? (e.g. should it include mom-and-pop operations, as well as corporate chains? should questionable "non-profit" activities be included?)

- o What is the extent of publicly-subsidized commercial service provision in Ontario?
- o What should be the criteria for determining if and when commercial service provision is desirable and appropriate in particular program fields?
- o What role, if any, should the commercial sector play in Ontario's human services (e.g. provider, funder, management consultant?)
- o Are there any human services which should not be provided by commercial organizations?
- o Should there be provincially-enforceable restrictions on commercial service provision on the basis of factors such as: chain ownership; absentee ownership; percentage control of the market; corporate concentration; profit levels; geographic concentration; and the vulnerability of service users?
- o If there is to be commercial provision of certain services, what mechanisms/protections are required to ensure: equal access to services; accountability to the government, the public, and service users; high quality of service; full disclosure of information, including profit levels and ownership?

3. That the outcome of the review be a statement of the provincial government's policy on and future plans for commercial service provision.

4. That the policy review be an open and public process which would allow sufficient time for public hearings and presentations.

5. That, as an interim measure while the policy review is being conducted, the provincial government take immediate steps to improve accountability, access to services and to information, and monitoring of quality of care in all services currently provided by commercial operators. These steps would include:

- o the introduction and enforcement of clear and measureable standards of quality of service;
- o full public access to all inspection reports and complaints investigations;
- o full public access to organizations' financial reports and ownership information;
- o access by service users to an independent advocate or grievance procedure;
- o provincial regulation and inspection of rest homes/retirement homes and boarding homes;
- o the introduction of a mechanism to ensure equal access to nursing homes, regardless of financial circumstances and level of care needed.

To the Municipality of Metropolitan Toronto, we recommend:

6. That the Municipality of Metropolitan Toronto immediately evaluate the quality of services provided by commercial day care centres and homemaking agencies, and that there be a public report on the findings.

7. That no new purchase-of-service contracts be awarded to commercial agencies until the evaluation has been completed.

1.0 INTRODUCTION

1.1 Statement of the Issue

The development of human services for profit appears to be gaining momentum in Ontario. Virtually all of the province's nursing home and rest home beds, almost half of the licensed day care spaces, and over a third of the capacity of children's residences are currently being operated by private entrepreneurs. The number of commercial homemaking and nursing agencies seems to have grown with increased government funding of home support services. Hospital management represents the commercial sector's most recent attempt to gain a foothold in the health care field.

The expansion of the commercial sector's role in human services must be understood as part of a larger movement to transfer responsibility from government to private individuals and organizations. Known as "privatization" or "reprivatization", this trend is accompanied by increasing government withdrawal from service delivery, regulation, and/or funding. As the government's role in human services declines, the burden of responsibility shifts to families, communities, and private enterprise. In Ontario, privatization is being pursued in various ways in addition to the promotion of for-profit service delivery. These include: imposing user fees for many kinds of services, contracting with the voluntary sector for direct service provision, recruiting churches into the service delivery role, increasing dependence on employers for essential social benefits, and re-activating the family as the "social service of first resort" for children and elderly parents.

It should be stressed that "privatization" is not synonymous with for-profit service provision; not all privatization proposals specifically call for greater involvement of the commercial sector. In some privatization proposals, any "private" organization, either voluntary or for-profit, will do, as long as the service provider is not government. In general, however, privatization favours the commercial sector since the goal of profit-making is assumed to be a primary contributor to greater efficiency. The encouragement of service provision by for-profit organizations is thus an integral part of the market approach advocated by proponents of privatization.

Although the push to commercialization is only one form privatization may take, it is a significant one which warrants special attention. Historically, the for-profit sector has not played a major role in the provision of human services in Canada. In fact, the absence of the profit motive was once considered to be one of the distinguishing characteristics of a social welfare system. The trend to commercial service provision should be examined precisely because it is a new development with potentially serious and far-reaching consequences.

We do not yet understand the full implications of the increasing commercialization of social and health services in this province. However, some worrisome trends are beginning to emerge in the United States where hospitals, prisons, home support services, nursing homes, day care for children, and group homes are provided by commercial operators. Serious questions are being raised about the effects of for-profit provision on quality of care, access to services, accountability to the community and to government, and about its impact on labour and the voluntary sector.

The risks associated with expanding the role of the for-profit sector appear to be substantial. The alleged benefits, on the other hand, are as yet unproven. The possibility of domination of social programs by commercial interests should make us wary about increasing our reliance on the for-profit sector. Yet, the provincial government appears to have no overall policy on commercialization and the implications of this trend are not being adequately examined by our politicians and other decision-makers. In an effort to begin such an examination, this paper will explore those implications and issues which must be addressed in future policy development.

1.2 Purpose and Scope of the Report

The starting point for this paper is the assumption that decisions about the financing and delivery of human services should be based on the needs of people requiring service. The trend toward privatization and commercialization raises two important questions which appear to challenge this assumption:

1) What is the impact of privatization and commercialization on the government's capacity, legitimacy, and willingness to play an active and positive role in meeting human needs? and

2) Is there an inherent tension between human service delivery and the profit-making goal of commercial enterprise which creates a potential for a lowering of quality of service, conflicts of interest and inadequate accountability?

It is from the perspective of the above questions that this report will explore both the practical and philosophical issues in the trend to commercial service provision. Specifically, it will provide an overview of the literature on privatization and for-profit service provision, examine the experiences in other jurisdictions (most notably the United States), document the major trends and issues in Ontario, and analyze the implications for future policy development. The effects of commercialization will be addressed primarily in relation to:

- o accountability to service users and to government;
- o influence on public policy;
- o quality of service;
- o equity (i.e. equality of access and equality of treatment); and
- o cost effectiveness.

This paper is organized in six chapters. Chapters 1 and 2 provide definitional and theoretical perspectives on privatization and commercialization. Chapter 3 describes the Ontario government's policies on privatization, documents the scope of for-profit provision in Ontario, and offers an analysis of the major trends. Chapter 4 summarizes the development and consequences of commercialization in the United States. Chapter 5 describes the issues and the implications of commercial service provision in Ontario. Finally, the conclusion and recommendations are presented in Chapter 6.

Throughout this report, the words "for-profit", "proprietary", and

"commercial" will be used inter-changeably to refer to organizations or individuals providing social or health services and which are, in most cases, incorporated under the Business Corporations Act. The primary aim of proprietary corporations is to generate surplus revenue for the personal gain of owners or stockholders. A non-profit organization, by contrast, is by law required to use surplus revenue to further the goals of the organization and to carry out its functions "without purpose of gain to members". (Section 126, The Corporations Act). Although some "mom and pop" group home or day care operators are not incorporated, they would still legally qualify as for-profit organizations. These operations will be included in our discussion of commercial service provision although, wherever relevant, a distinction will be drawn between the large, chain-operated businesses and the small "mom and pop" commercial operations.

It is perhaps necessary to clarify again the distinction between commercialization and privatization. "Commercialization", as used in this paper, refers to the trend to for-profit human service provision. "Privatization" is a broader category which includes commercialization as one of a number of strategies aimed at shifting responsibility for social welfare from the public to the private sector. Unless otherwise indicated, the term "private sector" is synonymous with "non-governmental" and includes voluntary organizations and proprietary agencies.

2.0 THE PUSH FOR PRIVATIZATION: ARGUMENTS FOR AND AGAINST

Three developments have contributed to the push for privatization. First, the desire to curb government spending has become reflected in public policy. Many advocates of privatization maintain that government over-spending, particularly on social programs, has been responsible for inflation and economic decline.[1] Governments have responded by introducing social spending restraint programs, diverting resources to the commercial sector, and looking for alternative sources of funding and ways of providing human services.

Second, the perception of a growing dissatisfaction with and loss of trust in government has provided an added rationale for privatization. Critics charge that government activity is inherently non-productive and inefficient and that governments have become too large, bureaucratic, and intrusive. Citizens, it is argued, are withdrawing their support for government because they no longer believe that it represents their interests. In the United States, the tax revolts in California and Massachusetts are frequently cited as examples of the erosion of confidence in government. This concern has also been expressed in Canada as evidenced by the creation of Ontario's Committee on Government Productivity in the early 1970's. The private sector, by contrast, is seen as flexible, innovative, responsive, and efficient. The way to restore trust in government, proponents of privatization argue, is to shrink the public sector and rely more on the private sector, particulary on commercial enterprise.[2]

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1. This observation has also been made in: Peter Faid, "Privatization or Deprivation?" First Reading, Edmonton Social Planning Council, Vol. 3, No. 718, July - August 1984; and Marvyn Novick, "Social Policy Cutbacks: What's At Stake?", Policy Alternatives, Ottawa: Canadian Centre for Policy Alternatives, Spring - Summer 1983.

2. See, for example: A.R. Bailey and D.G. Hull, The Way Out, A More Revenue Dependent Public Sector and How It Might Revitalize the Process of Governing, The Institute for Research on Public Policy, Montreal: 1983; and F.S. Savas, Privatizing the Public Sector: How to Shrink Government, Chatham House Publishers, Inc., Chatham, N.J., 1982.

Third, privatization has been given a push by the increased demand for services by people who view the marketplace as the primary source for meeting their needs.[3] The commercial sector's involvement in human services originated with the provision of services to those able to pay. This pattern has largely continued and is well illustrated by the day care situation in Canada. As a Health and Welfare Canada publication points out: "Commercial centres increase the availability of services to the middle- and upper-income groups."[4]

Following is a response to these developments and some of the arguments underlying privatization, as well as a discussion of three themes or approaches which are common to most privatization proposals: competition; selectivity; and reliance on the commercial sector.

2.1 Responding to the Attack on Government and the Welfare State

The attack on government bureaucracy and efficiency may be largely spurious. It is possible that declining confidence in government may relate more to the behaviour and attitudes of some public officials than the actual scope of government activity. Similarly, it must be acknowledged that business, too, may be bureaucratic and inflexible, or that there is a comparable drop in trust in the business community.[5] Furthermore, as one commentator notes:

> "Why should politicians be any better at preventing cost overruns by private suppliers than at

3. Sheila Kamerman, "The New Mixed Economy of Welfare: Public and Private", Social Work, January - February, 1983, p. 5.
4. National Day Care Information Centre, Status of Day Care in Canada, 1983, Health and Welfare Canada, p. 8.
5. Richard C. Rich, "Goodbye Government", Community Action, Vol. 1, No. 5, 1983, pp. 28-29.

> controlling their own department? And the assumption that public managers lack any incentive to control costs must also be questioned ... There is no obvious reason why the diverse stockholders in the modern corporation should be any more effective than voters in holding down waste."[6]

There is little evidence to support the claim that private delivery of services is less costly than public. An American study of private contracting arrangements with local governments found that:

> "Except possibly for the collection and disposal of solid wastes, objective and statistically valid data on comparative costs of similar services provided by the public and private sector are generally lacking."[7]

The increased cost of monitoring private delivery of human services is a further reason to doubt that substantial cost-savings can be achieved by privatization. Several health care economists have observed that a mixed public-private system is likely to be more expensive than either a public system or a completely unregulated private system.[8] The problems of managing and administering selective, rather than universal programs, add to the

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6. Michael Krashinsky, "Some Limitations on the Usefulness of Revenue Dependency: Why Governments Often Produce What they Subsidize," Canadian Public Policy, X:1:35, 1984, P. 39.

7. D. Fisk, H. Kresling, and T. Mullen, Private Provision of Public Services: An Overview, The Urban Institute, (Washington, D.C.: 1978), p. 99.

8. R.G. Evans, "Health Care in Canada, Patterns of Funding and Regulation", in G. McLachlan, and A. Maynard (eds.), The Public Private Mix for Health, London: Nuffield Provincial Hospital Trust, 1982, p. 417.

difficulty. It is significant that administrative health costs are far higher in the United States than in Canada, despite the U.S.'s extensive reliance on private delivery and funding, and that health care costs have risen much more dramatically in the the U.S. than in Canada.[9] These facts suggest that increasing privatization does not necessarily lower costs, and may, in fact, exacerbate cost escalation.

Even if privatization were to reduce costs, the question remains: costs for whom? The ultimate aim of most privatization proposals is to shift the burden of costs from the tax-supported public system to the users of service. This may be done directly, by the imposition of user charges, or indirectly by delegating responsibility to a lower lever of government.[10] Either way, the effects on equity and access will be negative, with the biggest burden falling on people with low incomes.

The second cost-related argument associated with privatization is that social spending is non-productive and must, therefore, be curbed. Yet, despite intense debate, little evidence has been produced to demonstrate that government expenditures are inherently less productive than private investments.[11] Similarly, there is significant disagreement over whether social spending constitutes a threat to productivity and a drain on the economy. A recent report by the Organization for Economic Cooperation and Development (OECD) found that social spending was highest in some of the most productive European countries, such as West Germany, Belgium and the Netherlands.[12] This suggests that social welfare expenditures do not necessarily make people and countries lazy and non-competitive. The case for social development

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9. Geoffrey Weller and Pranlul Manga, "The Push for Reprivatization of Health Care Services in Canada, Britain, and the United States, "Journal of Health Politics, Policy, and Law, Vol. 8, No. 3, Fall 1983, p. 500.

10. Ibid.

11. Social Planning Council of Metropolitan Toronto, ... And the Poor Get Poorer, 1983, p. 90.

12. Organization for Economic Cooperation and Development, "Social Expenditure: Erosion or Evolution?", OECD Observer, No. 126, January, 1984.

spending has also been taken up by others, like Liberal Senator Jack Austin, who argue that investment in people, through social development spending, is a pre-requisite to economic prosperity.[13,14]

Since government spending is a reflection of political choices and priorities, the desire to curb social spending must be seen as an attack on particular government policies and on the value of the welfare state. However, the question of how human services should be paid for is not merely a debate over funding mechanisms. The collective financing of human services through taxation is one of the pillars of the welfare state, the other being universality. Together, they promote the dignity of citizens by guaranteeing access to services, while avoiding the stigma and exclusion associated with selectivity.[15]

Social spending restraint is not just a tool of fiscal management; it is a political symbol which may serve as a substitute for needed structural reform. Politicians hope that their efforts to curb social spending will be seen by voters as a positive response to economic problems, such as inflation and unemployment. The symbol of fiscal restraint is used to indicate a shift in priorities toward more efficient and effective management of the economy.[16] However, as one observer points out:

> "Why adaptations to restraint necessarily bring more efficiency is not clear. The result can just as easily be inefficient adaptations, with powerful interests protecting their programs at the expense of the less influential and articulate."[17]

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13. Jack Austin, "You Can't have economic growth without social spending", Toronto Star, Saturday, February 18, 1984.

14. For a fuller discussion of this argument, see: Theodore W. Schultz, Investment in Human Capital, The Free Press, New York: 1971.

15. Novick, Policy Alternatives, Op. Cit., p. 20.

16. Graham Riches, Spending is Choosing, Restraint and Growth in Saskatchewan's Personal Social Services, 1966 -1977, Social Administration Research Unit, Faculty of Social Work, University of Regina, Regina, Sask., 1979.

17. Marvyn Novick, "Social Policy: The Search for a Provincial Framework" in Donald E. MacDonald (ed.) The Government and Policies of Ontario, Toronto: Van Nostrand Reinhold, Ltd., 1980, p. 384.

The most fundamental issue underlying privatization is the government's legitimacy and role in social welfare, not its performance or cost. The advocates of privatization oppose anything other than a residual government role in human services. At the same time they urge a greater role for the traditional institutions of family, church, community and the marketplace. In fact, the fear is frequently expressed that a government supported social welfare system will displace these other institutions. Savas, for one, argues that:

> "The family may give way to Departments of Health, Education, Welfare, and Human Services. The priest, minister, and rabbi can be replaced by a community mental health agency. Voluntary groups can be supplanted by issue-oriented lobbies that seek to use the force and majesty of government to impose their values on others."[18]

According to the residual view, government involvement should be restricted to protecting citizens from the worst market abuses and establishing a "safety net" for people who simply cannot compete in the marketplace. Such a view is in stark contrast with the position that the government should exercise considerable leadership and commitment in ensuring that all citizens are guaranteed a decent standard of living as a matter of right. In this latter view, public responsibility for human services is considered to be both legal and moral and is based on the following principles:

a) guaranteed entitlements, independent of work performance, the marketplace, or self-reliance;

b) a commitment to distributive justice and substantive equality (rather than merely procedural equality); and

c) social solidarity, the principle of collective or mutual responsibility for all citizens.[19]

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18. Savas, Op. Cit., p. 4.

19. Gosta Esping-Anderson, "After the Welfare State", Working Papers, (May - June, 1982), p. 36.

Human services can be justified as social entitlements of citizenship on two grounds: their ability to meet pressing human needs; and their contribution to building the kind of society in which we want to live. The Social Planning Council of Metropolitan Toronto has pointed out in a previous document that "when social neglect is allowed to prevail, we not only inflict human pain on the needy and dependent, we also violate the collective integrity of the community to which we all belong."[20]

2.2 Competition, Consumer Sovereignty, and Equity

To the advocates of privatization, competition is the key to ensuring the best quality of service at the lowest possible cost since the quantity of services demanded by consumers will, in theory, be matched by the amount offered by producers. Consumers are considered sovereign because they are free to choose from among competing service providers who must attract and retain clients/consumers to stay in business. As a result, high quality services will result at competitive prices.

Although the marketplace competition model is promoted frequently for the health care field, many proponents of competition recognize that a *laissez faire*, free-market approach is probably not applicable to human services. They would, nevertheless, like to increase the influence of market forces as much as possible. The resulting "pseudo-market" would combine elements of the free market with government regulation.

In a book written by two Canadian federal civil servants, a new method of "full-cost revenue dependency" is advocated. This scheme entails identifying, measuring and fully costing public services and then pricing and selling them to the public. Some services would be sold by the government, while others would be made available by the private market. Health services and education are seen to be prime candidates for the application

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20. Social Planning Council of Metropolitan Toronto, SPC Policy Dossier, April 1982, p. 4.

of revenue dependency.[21] A major criticism of this approach is that it would necessitate costly government monitoring to ensure that the public benefits.[22]

A similar proposal is made by a Canadian health economist in a book published by the Fraser Institute. In calling for an "efficient market for health services", Ake Blomquist proposes the elimination of government subsidies to hospitals and medical insurance, the removal of restrictions on new doctors and new hospitals, and open competition between public and private health insurance plans.[23]

The competition strategy as a way of improving service quality and keeping down costs can be criticized on two major grounds: 1) the inapplicability of "consumer sovereignty" to human services; and 2) the effects of competition on equity. One of the pre-conditions for successful competition and consumer sovereignty is perfect knowledge. However, since consumer ignorance is one of the main sources of market failure in the first place, it is unlikely that reliance on consumers as the primary focus of competition would work.[24,25] In fact, "provider sovereignty" would probably be a more appropriate description of what goes on in the human services, particularly in health care where doctors exercise substantial control over demand for services. Consumers are often not in a good position to choose among competing treatment and services or to assess the competencies of practitioners. A similar situation has been found to exist in day care where:

> "... Distrust of the market might be justified, where producers might well know more about the

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21. Bailey and Hull, Op. Cit.

22. Krashinsky, Canadian Public Policy, Op. Cit., p. 39.

23. Ake Blomquist, The Health Care Business, Vancouver: The Fraser Institute, 1979.

24. Weller and Manga, Op. Cit., p. 510.

25. Some of the other requirements of a successful competitive market, such as a homogeneous product and free entry and exit of producers, also do not exist in the human services. See, for example: Bonita A. Wlodkowski, "Caveat Emptor in Health Care", Political Science Quarterly, Vol. 98, No. 1, Spring 1983.

> quality of service than do consumers ... The purchaser of the service - the parent - is not after all the direct consumer ... Aside from some obvious physical characteristics of the centre ... there are few easily observable characteristics that might enable the parent to judge good day care."[26]

The second criticism of the competitive marketplace approach to human service centres on its impact on equity. In a competitive market system, freedom of choice, where it exists at all, belongs not only to the consumer, but also to the service provider. In situations where there is insufficient market demand or the production of certain services is not profitable, competition cannot be relied on to ensure the availability of services. The beneficiaries of competition and freedom of choice will, therefore, be those with ability to pay; people who are poor or otherwise vulnerable, such as elderly or handicapped people, cannot be guaranteed either access to or equality of treatment. Although it could be argued that these groups do not fare particularly well under our present system of services, private control over formerly public funding decisions would "generate new opportunities for marketplace neglect of the poor."[27] Canadian health economist, Robert Evans, summarizes why the market will never function in health care, as follows:

> "'Your money or your life' is not a market offer. And given the cost and complexity of modern health care, this group with inadequate personal resources of wealth and information will at various times take in all of us."[28].

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26. Michael Krashinsky, Day Care and Public Policy in Ontario, Toronto: Ontario Economic Council, 1977, p. 115.

27. Daniel Sigelman, "Palm-Reading the Invisible Hand: A Critical Examination of Pro-Competitive Reform Proposals", Journal of Health Politics, Policy and Law, Vol. 6, No. 4, Winter 1982, p. 593.

28. Evans, Op. Cit., p. 420.

A crucial issue, of course, is whether human services should be considered public or private goods. Predictably, the proponents of privatization urge the re-classification of many services now considered "public goods", such as education, health, and most social services. Blomquist argues that in health care only the control of contagious disease should be thought of as a public good; all other health services should be treated as private goods for which individuals should assume personal responsibility.

> "While there would presumably exist a wide agreement that the taxpayers' money could legitimately be used to finance inoculation from which the whole community would jointly benefit, the same agreement might not exist with respect to cancer and heart disease ... Less dramatically, the taxpayer may be even less happy paying for removing the tonsils of the brat next door. ..."[29]

2.3 Access to a Minimal Level of Care, Selectivity, and Universality

One way in which privatization deals with the equity issue is to try to define it out of existence by lowering the accepted level of care or service to which people would be entitled. Equal access to a minimum level of care would be guaranteed; access to service above that level would depend on ability to pay. What is at issue, of course, is where the dividing line should be drawn. Typically, the advocates of privatization call for a "safety net" approach which would preserve access to only a basic level of service. According to this perspective, the definition of poverty is restricted to the absolute barest sense of the term - the minimum required to allow physical subsistence.[30] The most serious objection is to the ethical view reflected in this approach:

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29. Blomquist, Op. Cit., p. 13-14.

30. Nick Bosanquet, Economics: After the New Right, Boston - The Hague - Dordrecht - Lancaster: Kluwer-Nijhoff Publishing, 1982, p. 121.

> "It implies that society has an interest in maintaining the lives of its members on a purely physiological or animal basis but does not care about whether people's ability to function mentally and socially is maintained. Life is not merely physiological existence: it is also about relationships, activity, and dignity.[31]

Another criticism stems from the fear that the minimum level will not be adequate and that a two-tiered system will result, with public services for the poor and higher-quality, private services for the non-poor. Privatization advocates accept this position, arguing that since we cannot afford "the best possible care for all", we should at least guarantee a basic minimum.

Related to the concept of minimal level of care is the proposal to increase the number of selective programs to people in real need and eliminate universal provisions. However, critics of this approach point out that selective programs are potentially stigmatizing and not necessarily more efficient or progressive than universal ones.[32] As Esping-Anderson notes:

> "There is an important political logic to a welfare state built around universalistic social programs. When the welfare state's clientele includes the entire population, rather than narrowly targeted problem groups, the likelihood of a middle class backlash is significantly reduced. In other words, universalism in social programs manufactures its own political constituency, which in turn helps maintain a basic

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31. Ibid.

32. See, for example: "With No Stigma Attached: Family Allowances and the Question of Universality", Social Infopac; Social Planning Council of Metropolitan Toronto, February 1983, Vol. 2, No. 1.

sense of social solidarity and shared responsibility."[33]

In Canada, the truth of this observation is borne out by the public support for universal Medicare and Family Allowances, and the relative lack of opposition to the curtailment of selective programs funded under the Canada Assistance Plan.[34]

2.4 Privatization and Commercialization

Although privatization is not restricted to for-profit service provision, the commercial sector occupies a prominent position in most privatization proposals. An alleged advantage of the market is that it enforces relatively automatic penalties and rewards. The laws of supply and demand and the profit motive are thus assumed to provide incentives to cost reduction, operating efficiency, and effective performance.[35] In one commentator's words:

> "The historical absence of the profit motive in social services has contributed to shoddy agency management, poor accountability procedures, and service of questionable or uneven quality. Recent political and economic pressures have changed that. The philosophy, technology and vocabulary of big business are now part of everyday agency life.[36]

E.C. Manning, the former Social Credit premier of Alberta, provided a similar rationale when he introduced the concept of privatization to Ontario

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33. Esping-Anderson, Op. Cit., p. 32.
34. Social Planning Council of Metropolitan Toronto, Democracy, Equality, and Canada's Economic Future, 1983, p. 62.
35. Hal Rainey, Robert Backoff, and Charles Levine, "Comparing Public and Private Organizations", Public Administration Review, March-April, 1976, p. 235.
36. Kenneth H. Watson, "Efficiency Versus Process", Public Welfare, Summer, 1983, p. 19.

in 1970. On the basis of the following argument, he submitted proposals to governments and business leaders calling for the expansion of the for-profit sector in the provision of human services:

> "... The thing to do is to launch a major counter expansion of the private sector into certain fields (social services, in particular) which have erroneously come to be regarded as lying within the jurisdiction of the public sector alone ... Private enterprise must seek to improve the efficiency and quality of essential social services by directly utilizing for social action some of the management methods and skills which the competitive pressures of the private sector have developed to high degree."[37]

Peter Drucker, one of the foremost American proponents of privatization, further suggests that the for-profit organization is innovative because of its need to take risks, and that it is the only institution in society with a test of performance, namely profit. He observes that:

> "No matter how inadequate profitability may be as an indicator, in certain respects, it is there for all to see. [However], the strongest argument for 'private enterprise' is not the function of profit. The strongest argument is the function of loss. Because of it, business is the most adaptable, and the most flexible of the institutions around."[38]

There is support for Drucker's argument of greater flexibility. Krashinsky, for example, suggests several desirable characteristics of

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37. M & M Systems Research Ltd., Requests for Proposals and Social Contracts, A Strategy to Advance the Role of Private Enterprise in Canada, Edmonton: January 1970, p. 3.

38. Peter Drucker, "The Sickness of Government", Public Interest, Winter 1969, p. 21.

commercial day care centres which he attributes to "the lure of increased sales and profits": the capacity and willingness of commercial centres to meet increased demand; and their ability to respond to changes in preferences among parents. (It should be noted, however, that Krashinsky also identifies quality control as a problem in commercial centres).[39]

The most basic objection to for-profit human service provision is that:

> "There is an inherent contradiction between the purposes of human service delivery and the profit-making goal of entrepreneurship. Each has its place in the institutional fabric of a democratic capitalist society, but they are not the same place. Attempts by one organization to "have it both ways" lead to systemic conflict ...[40]

There are a number of ways in which this contradiction may manifest itself, among the most serious and likely being a lowering of quality of care and restrictions on access to service. Since the goal of the proprietary firm is to maximize profits, there is a temptation to cut costs at the expense of service quality and workers' salaries or to limit service to those with ability to pay. The likelihood that a large segment of the population will either be unserved or inadequately served is identified in the following observation:

> "... The evidence to date suggests that the proprietary approach ... will reach at least half of the population and, at worst, will reach that half which has proportionately fewer social needs than families of limited income. The outcome would be a two-tier system in which the expanded proprietary services reach more

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39. Krashinsky, Day Care and Public Policy in Ontario, Op. Cit., p. 118.

40. Dan Rubenstein, Richard E. Mundy, Mary Louise Rubenstein, "Proprietary Social Services", The Social Welfare Forum, Proceedings of the 105th Annual Forum of the National Conference on Social Welfare. New York: Columbia University Press, 1979, p. 137.

> and more middle- and upper-class families, without a compensating attention to the needs of the less affluent."[41]

For-profit provision may also act as an incentive to engage in "cream skimming", the practice of serving only the most profitable or least problematic clients. In a speech to the Committee on Social Development, Larry Grossman, then Minister of Health, stated:

> "Another issue we must address is the right of nursing homes to pick and choose their patients because a profit motivated system appears to have a built-in preference for patients who need the least attention.
>
> The result is not rational in terms of the effectiveness of the health care system. And in broader terms, I question whether such freedom of choice is proper for institutions which are essentially publicly funded."[42] (Emphasis added).

Moreover, at a time of social spending restraint and alleged "scarce resources", it may be neither efficient nor rational for a government to subsidize the for-profit sector with tax dollars. Since proprietary firms are not required to re-invest profits to improve or expand services, a substantial amount of money is leaving the human service system, money which could have been used to benefit service recipients or to develop additional services.

Although voluntary agencies do not necessarily provide better services, they do have some advantages which for-profit organizations do not and cannot possess. First, voluntary agencies are run by community boards which play an important role in promoting accountability to service users

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41. Robert Morris, "Government and Voluntary Agency Relationships", Social Service Review, (September 1982), p. 342.

42. Statement by the Honourable Larry Grossman, Minister of Health to the Committee on Social Development of the Ontario Legislature, November 1982, p. 23.

and to government. The citizen board is seen as an essential protection for vulnerable people who are receiving social services and "who are least able to protect themselves in a proprietary climate."[43] Second, voluntary organizations are prohibited by law from generating a profit which can be used for the personal gain of employees or board members. Service users generally prefer to obtain services from voluntary agencies; they are considered to be more "trustworthy" precisely because of the legal constraint on distributing profits.[44] Clearly, the legal prohibition alone does not guarantee a high quality of service; it does, however, lessen the potential for the kind of conflict of interests entailed by the profit-making goal, the *raison d'etre* of the proprietary corporation.

With respect to accountability, there is also a concern that the profit motive may be incompatible with government regulation.[45] If past record is any indication, the commercial sector's relentless campaigns against government license-setting and regulation in the day care and nursing home fields are indeed reasons to suspect their commitment to a high quality of services.

The proprietary organization's oft-cited potential for flexibility and adaptability may also have negative consequences. If profit is the goal of an organization, there is not likely to be an inherent loyalty to a service, a client, or even a community. An unprofitable service or client group will be dropped in favour of more profitable ventures. The allegedly high rate of "corporate deaths" among some proprietary human service agencies, such as children's residences, suggests that instability may be a problem in the commercial sector.

The profit motive may also limit the development of innovative services. In the mental health field, for example, it has been reported

43. Joseph H. Reid, "The Role of the Voluntary Sector", Social Welfare Forum, 1976. New York: Columbia University Press, p. 67.

44. Henry B. Hansmann, "The Role of Nonprofit Enterprise", The Yale Law Journal, 89 (April 1980), p. 845.

45. Rubenstein, Mundy, Rubenstein, Op. Cit., p. 134.

that financially risky new services are not likely to be offered by for-profit firms since new programs are assessed in terms of potential profitability, as well as effectiveness.[46] Similarly, the commercial sector's potential for responsiveness to need may also be more mythical than real. The critics of for-profit human services argue that proprietary firms may create needs artificially and that increased demand may not reflect growing needs. As Evans points out in relation to health care:

> "In a private, for-profit setting, sales promotion is a means to greater profit. The match between service and clinical need is of significance only insofar as it may relate to future sales (or lawsuits)."[47]

Brian Abel-Smith, a British advisor on social policy, maintains that assigning some social programs to the marketplace would result in insufficient investment in public services. Consequently, there would be an increase in the gap between "private affluence and public squalor" in the human service field. He suggests, as a general rule, that the community should not permit for-profit service provision:

> " ... where dependent people will be unable to protest or to remove their patronage, or where unethical conduct, inspired by a search for profit, may have very serious consequences for the consumer."[48]

Finally, related to Abel-Smith's concerns is the fear that governments will become dependent on the proprietary sector to achieve social policy objectives. As Novick observes:

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46. T.L. Gessner, and D.S. Morisseau, "Under the Golden Psi: The Franchising of Mental Health; Psychiatry, Vol. 43, November 1980, p. 301.

47. Evans, Op. Cit., p. 411.

48. Quoted from Alfred J. Kahn, Theory and Practice of Social Planning, Russell Sage Foundation, (New York: 1969), pp. 182-183.

> "Profit organizations acquire the capacity to organize and supply services on a volume basis. It is when these ventures become the repository of technical knowledge and information, and serve large numbers of people, that control of the market sets in.
>
> The risk ... is that the role of government drifts into states of passive intervention, responding to the momentum of the profit groups. The regulated begin to set the conditions of their own regulation."[49] (Emphasis added).

The government's willingness and ability to play an active and positive role in shaping social policy may be weakened by its reliance on the commercial sector. Instead of assuming a leadership role in human services, the government may be forced to limit itself to "superficial monitoring of social welfare activities and intervening when government funds are misused or freedom of the market is restricted."[50] Hence, there is the danger that the mandate of elected legislative bodies to make and implement social policy becomes shared with private corporations whose primary interest is profit.

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49. Novick, "Social Policy: The Search for a Provincial Framework", Op. Cit., p. 388.

50. David Stoesz, "A Wake for the Welfare State: Social Welfare and the Neo-Conservative Challenge", Social Service Review, (September 1981), p. 404.

3.0 THE COMMERCIALIZATION OF HUMAN SERVICES IN ONTARIO

3.1 Privatization as Public Policy

Until fairly recently, the government was not expected to play an active or major role in social welfare. Most of our human services developed initially under private, non-profit auspices by charitable groups, religious organizations and voluntary associations. In Ontario, the exceptions include provincial institutions for mentally retarded people, psychiatric hospitals, public poorhouses, and prisons, all of which were developed under governmental auspices. However, the non-governmental sector has historically been unable to respond adequately in periods of rapidly increasing needs. Consequently, since the Depression, both the federal and provincial governments of Canada have assumed major roles in social welfare.

In Ontario, further shifts occurred between 1946 and 1971 with the expansion of the provincial government's involvement in social policy. The 1940's saw the government primarily involved in the regulation of non-governmental services; the 1950's was the period of capital expansion or "government as builder"; and the 1960's marked the emergence of the service state with the government as a major provider of human services.[1] The introduction in 1966 of federal cost-sharing under the Canada Assistance Plan and the increasing demand for services further expanded the role of government. Many voluntary associations also managed to persuade legislators that the services they had been providing were in the public interest and that they should be public responsibilities, eligible for public funding.

However, in 1971 the Ontario provincial government began to lean toward privatization. The report of the Committee on Government Productivity (COGP) stated that:

"In future, selective reprivatization of program

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1. Vernon Lang, The Service State Emerges in Ontario, Ontario Economic Council, January 1974, pp. 47-55.

> delivery could tap community skills and resources needed to meet policy objectives. These skills may be found in non-profit organizations, in private, profit-oriented corporations, or in community corporations organized by special interest groups".[2]

In recent years, the privatization themes of "minimum costs for maximum service" and transferring responsibility to the private sector have become even more clearly reflected in Ontario's government policy, as the following quotation from a Management Board document illustrates:

> " ... in the late 60's and early 70's, government managers learned to manage in a climate of growth. By the mid and late 70's, it became important to hold the line, increase productivity, foster public self-sufficiency, and transfer responsibility back to the private sector. Today's thrust of 'more for less' challenges management to be creative in a time of restraint and increasing public scrutiny."[3]

By 1984, we seem to have veered 180 degrees from the time when the government first established its role in social welfare. Government is beginning to withdraw from its previous commitments; its capacity and legitimacy in meeting human needs are once again being questioned. The introduction of government social spending restraints[4] and the development of a rationale for privatization are contributing to a shift from public to private provision of services, with the role of the commercial sector growing in importance.

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2. Committee on Government Productivity, Interim Report Number Three, Report on the Structure of Government and Interim Recommendations to the Executive Council, December 1971, p. 51.

3. Ontario Management Board of Cabinet, Ontario's Management Philosophy, OPS Management Series, Toronto: Queen's Printer, 1981, p. 3.

4. For documentation of the impact of social spending restraints on Ontario's human services, see: Social Planning Council of Metro Toronto, And the Poor Get Poorer, 1983; and Social Planning Council of Metro Toronto, Voluntary Sector at Risk, 1981.

3.2 Ontario Government Policies on Commercialization

Following is a review of the policies and practices of two ministries with major responsibility for human services - the Ministry of Community and Social Services (COMSOC) and the Ministry of Health (MOH). The sources of information include policy statements, discussion papers, Ministers' speeches, and conversations with officials. The review is not intended to be exhaustive; rather, its purpose is to provide a framework for understanding the Ontario government's approach to commercial human service provision.

Differences Between Ministries

Although both COMSOC and the Ministry of Health fund proprietary agencies to provide services, there are some significant differences between the two ministries. The Ministry of Health appears to have a clearer, more unequivocal commitment to the use of the commercial sector than does COMSOC. Unlike the Ministry of Health, COMSOC provides no direct or ongoing funding to proprietary organizations. While the MOH directly funds private, for-profit nursing homes, COMSOC has an "arm's length" relationship with commercial service providers. For-profit services such as day care centres, children's residences, and homemakers enter into contracts with municipalities or Children's Aid Societies, not directly with the Ministry. Thus, although there is significant for-profit provision of social services, it is purchased by bodies other than the Ministry, albeit with COMSOC funds.

The apparent differences between the two ministries may be as much a function of convention and federal funding arrangements as of philosophy. Historically, social services have been provided by non-profit organizations and COMSOC has largely adhered to this convention, particularly with respect to directly-funded services.[5]

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5. This observation was confirmed in a letter from Robert McDonald, Deputy Minister of Community and Social Services, to the chairman of the Metro Toronto Social Planning Council's Privatization Project Committee, June 15, 1984.

Moreover, the federal Canada Assistance Plan (CAP), under which many COMSOC services are cost-shared, favours the non-profit delivery of services. Under the welfare services, or "likely to be in need", provisions of CAP, the only cost-shareable services are those provided by "non-proprietary" organizations. However, the costs of services provided by commercial agencies may be cost-shared if another provision under CAP - the "assistance" route - is used. If a provincial government chooses the latter alternative, a needs test must be imposed. This option is frequently less attractive then the non-profit route since needs testing may not always be seen as appropriate or desirable. Federal funding legislation , and not a philosophical difference, appears to be the major reason for COMSOC's unwillingness to provide direct, ongoing funding to commercial agencies.

The Ministry of Health, by contrast, is not similarly limited by federal cost-sharing regulations. The only requirement in the Canada Health Act is that services be publicly-administered.

Ministry of Community and Social Services

The Ministry of Community and Social Services has in the past not invited the involvement of the proprietary sector. In fact, there has been some ambivalence about the desirability of having certain services provided by commercial operators. The following excerpt from a discussion paper on residential services for mentally retarded people illustrates this point:

> "The Ministry should exercise considerable caution if any large entrepreneurs wish to develop services for the mentally retarded. Such projects should be subject to careful controls and guidelines developed after detailed consideration of the profit-making component. Monitoring of program, staffing patterns, and staff qualifications should be a high priority, particularly until the MCSS [Ministry of Community and Social Services] develops standards and guide-

lines for adult residences for the developmentally handicapped."[6]

Until recently, provincial legislation required certain children's services, such as child protection, to be provided by non-profit agencies. However, with the changes contained in Bill 77, "The Child and Family Services Act", there will no longer be children's services under COMSOC which must be non-profit. Bill 77 removes all previously-existing legal prohibitions against for-profit service provision and introduces the concept of an "approved agency", [7] which may be either non-profit or commercial. Therefore, unless prevented by the regulations, the commercial sector will in the future be able to make inroads into service fields from which it has historically been excluded.

Ministry of Health

In a 1983 speech to the Ontario Nursing Home Association, the Minister of Health, Keith Norton, stated that "the government of Premier William Davis does believe that private enterprise has a place in the provision of health care services in this province."[8] This is borne out by the fact that Ontario relies heavily on for-profit nursing homes and contracts with private firms, such as medical laboratories, to provide services to hospitals. More recently, commercial firms have been encouraged to move into other health-related areas such as hospital management, and homemaking services under the Home Care Program.

The Business Oriented New Development Plan (BOND) is another example of the Ministry of Health's desire to introduce market forces into

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6. Ministry of Community and Social Services, Community Residential Services for Developmentally Handicapped People, Program Development Series, Vol. IV, April 1983, p. 10.

7. Bill 77, An Act Respecting the Protection and Well-Being of Children and their Families, Queen's Printer for Ontario, 1984, p. 11.

8. Remarks by the Honourable Keith Norton, Minister of Health, to the Ontario Nursing Home Association, Toronto, Ontario. September 22, 1983, p. 14.

the health care field. Under BOND, hospitals are allowed to keep all revenues from higher fees for private and semi-private rooms and are encouraged to increase the number of commercial enterprises in which they engage. BOND was introduced in 1981 as "a positive step to encourage the public sector to benefit from private sector thinking and practice."[9]

Despite the MOH's financial and political commitment to the private sector, the Minister of Health has stated that:

> "There is no overall policy with respect to which services may be provided by for-profit operators, but rather each situation must be considered on an individual basis."[10]

Although there are no legislative requirements, the Ministry of Health favours the use of non-profit organizations for programs funded under the Community Mental Health Services program. Ministry guidelines specify that these services must be "managed by a non-profit board or committee."[11] Guidelines notwithstanding, however, the Ministry recently began to fund, on a pilot basis, two commercial boarding homes under the Community Mental Health Services program.

3.3 The Scope of For-Profit Service Provision in Ontario

A full documentation of commercial involvement in Ontario's human services would be a major undertaking. Because of time and resource limitations, we have restricted ourselves to the major service fields where information was most readily available: nursing homes, homes for special

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9. Ministry of Health, "Explanation of the Business-Oriented New Development Plan", p. 1.

10. Letter from Keith Norton, Minister of Health, to the chairman of the Metro Toronto Social Planning Council's Privatization Project Committee, August 10, 1984.

11. Ministry of Health, Community Mental Health Services Program Manual, July 1982, pp. 111-2 - 111-3.

care, rest homes/retirement homes, home support services, hospital management, day care centres, and children's residential services. We have not examined the increasing privatization of ancillary services in hospitals, such as medical labs, housekeeping, and food services, which is occurring through contracts with private firms; we have obtained only limited information on the provincially unregulated services, such as boarding homes and rest homes/retirement homes. However, even for some provincially-licensed services, such as children's residences, statistical information on the scope of commercial involvement was extremely difficult to obtain.

We recognize that there are service fields and methods of service provision not addressed in this report which might be considered to be "privatization" or "commercialization". For example, the increase in private adoption as an alternative to the publicly-funded CAS adoption system has the same consequences as most privatization approaches: service becomes limited to those with ability to pay.[12] Similarly, human services offered by professionals in private practice (e.g. social workers, psychologists) might also be viewed as "commercialization". Finally, there is the definitional "grey area" consisting of legally-incorporated non-profit organizations which engage in commercial activities or, alternatively, commercial agencies "disguised" as non-profit organizations.[13] Although the above are important areas which warrant examination, they were, however, felt to be outside the scope of this report.

3.3.1 Nursing Homes

The for-profit sector's involvement in Ontario's human services is greatest in the provision of nursing homes. In 1983/84, there were 332

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12. See: Lynn Ferguson, "The Real 'Cabbage Patch Kids': An Examination of the Canadian Private Adoption System", Paper No. 2, in the Occasional Papers in Social Policy Analysis, Department of Sociology in Education, Ontario Institute of Studies in Education, January 1984.

13. For a discussion of "entrepreneurism" or "commercialism" in voluntary organizations, see: Amitai Etzioni, and Pamela Doty, "Profit in Not-for-Profit Corporations: The Example of Health Care", Political Science Quarterly, Vol. 91, No. 3, Fall 1976.

nursing homes in Ontario with a total of 29,215 beds. Over 300 of these homes were privately owned businesses, operated by individual owners or as part of corporate chains. Approximately 24 non-profit nursing homes were owned and operated by hospitals or municipalities.[14]

Nursing homes are institutions providing "extended care" to elderly people and others who require a minimum of 1½ hours of nursing and personal care per day. Extended care generally lasts several months or years. Although most nursing home residents are over 65 years of age, there are also nursing homes for mentally retarded infants and adolescents, physically handicapped children, young adult stroke victims, and adults with psychiatric problems.

Nursing homes are provincially licensed and inspected by the Ministry of Health. Under the Nursing Homes Act, nursing homes may retain up to 25 percent of their capacity for people needing intermediate care which, unlike extended care, is not an insured service under OHIP. However, by 1983/84, virtually all nursing home beds were occupied by extended care residents for whom nursing homes receive a per diem rate of $42.35. The Ministry of Health pays $27.63 of this amount, through the Extended Care Health Insurance Plan, and the resident or his/her family is responsible for the remaining $14.72 per day. The resident co-payment is calculated to ensure that residents with no private sources of income, who are receiving the maximum OAS/GIS/GAINS benefits, will be able to pay the full co-payment and still be left with a disposable income of $96 per month.[15] In 1983/84, Ministry of Health expenditures for nursing homes totalled $241.7 million.[16]

Extended care is also provided in municipal and charitable Homes for the Aged, which are funded by the Ministry of Community and Social

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14. Information obtained from the Ministry of Health, July 1984.
15. Information obtained from the Ministry of Health, April 1984.
16. Information obtained from the Ministry of Health, July 1984.

Services. However, as Table 1 indicates, there has been a virtual moratorium on the expansion of both residential and extended care beds in Homes for the Aged. The growth in the number of nursing home beds, by contrast, is shown in Table 2.

TABLE 1

CHANGE IN NUMBER OF EXTENDED CARE AND RESIDENTIAL CARE BEDS IN HOMES FOR THE AGED ONTARIO, 1973 AND 1983/84

Year	Extended Care Beds	Residential Care Beds	Totals
1973[1]	12,246	13,796	26,042
1983/84	13,104	14,862	27,966
INCREASE or DECREASE	856 (7.0%)	1,066 (7.7%)	1,924 (7.4%)

[1] Based on calendar year.

Source: Ministry of Community and Social Services, June, 1984.

TABLE 2

CHANGE IN NUMBER OF LICENSED NURSING HOMES AND NURSING HOME BEDS ONTARIO, 1972/73 AND 1983/84

Year	Number of Nursing Homes	Number of Beds
1972/73	447	22,505
1983/84	332	29,215
INCREASE or DECREASE	-115 (-25.7%)	6,710 (29.8%)

Source: Ministry of Health, April and July, 1984.

A comparison of the data in Tables 1 and 2 reveals that the increase in extended care beds has been significantly greater in the commercial sector than in the municipal and charitable sectors. While the number of extended care beds in nursing homes grew by 29.8 percent from 1972/73 to 1983/84, there was an increase of only 7.0 percent in the number of extended care beds in Homes for the Aged for the period from 1973 to 1983/84. (Table 1 in the Appendix shows that the least growth has occurred in municipal Homes for the Aged.)

Table 2 also shows that the number of nursing homes has declined since the introduction of the extended care program, from 447 in 1972/73 to 332 in 1983/84. The reason, of course, is that nursing homes are becoming larger. In 1972/73, the average size was 50 beds; by 1983/84, this had grown to 88 beds. In the last decade, owners of small nursing homes have been selling their licenses to new owners, frequently to corporations, who have been constructing larger facilities with more beds.

Ontario appears to rely significantly more on the proprietary sector than does Canada as a whole for the provision of residential care to elderly people. According to information from Statistics Canada, presented in Table 3, 53.2 percent of the "special care" beds in Ontario, which include nursing homes, are owned and operated by proprietary agencies, compared with 37 percent for all of Canada. When Ontario's beds are subtracted from the total number of special care beds for elderly people in Canada, the proprietary sector in the rest of Canada accounts for only 26.9 percent, compared with Ontario's 53.2 percent.

TABLE 3

NUMBER OF SPECIAL CARE FACILITIES[1]
AND MAXIMUM BEDS
FOR AGED PERSONS
BY TYPE OF OWNERSHIP, CANADA AND ONTARIO, 1983

	CANADA		ONTARIO	
Ownership	Number of Facilities	Number of Beds	Number of Facilities	Number of Beds
Proprietary	1,118 (45.6%)	59,024 (37.0%)	434 (69.1%)	32,602 (53.2%)
Voluntary[2]	436 (17.8%)	37,00 (23.2%)	100 (15.9%)	9,767 (15.9%)
Government[3]	896 (36.6%)	63,490 (39.8%)	94 (15.0%)	18,868 (30.8%)
TOTALS	2,450 (100.0%)	159,514 (100.0%)	628 (100.0%)	61,237 (99.9%)

[1] "Special Care Facilities" include facilities with 4 or more beds, excluding hospitals.

[2] Includes "Religious" and "Lay".

[3] Includes "Municipal", "Provincial", "Public Undistributed", and "Federal".

Source: Statistics Canada, Inventory of Special Care Facilities, 1983.

3.3.2 Homes for Special Care

Many nursing homes are also licensed as Homes for Special Care (HSC), another program funded and administered by the Ministry of Health. The HSC program in 1983/84 served approximately 6,300 people discharged from provincial mental retardation or psychiatric facilities.[17] About 3,600 HSC residents are ex-psychiatric patients, while the remaining 2,700 are mentally retarded residents.

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17. Information obtained from the Mental Health Division, Ministry of Health, June 1984.

Two kinds of homes fall under the HSC program: nursing homes and residential homes for special care. The following table gives a breakdown of the number of residents in each type of home.

TABLE 4

RESIDENTS IN THE HOMES FOR SPECIAL CARE PROGRAM
ONTARIO, 1977/78 TO 1983/84

Type of HSC Home	Year	Number of Residents
Nursing Homes	1977/78	5,220
	1979/80	4,853
	1981/82	4,492
	1983/84	4,033[1]
Residential Homes	1977/78	2,157
	1979/80	2,196
	1981/82	2,186
	1983/84	2,249

[1]The decrease in HSC residents in nursing homes is due to the fact that residents are being admitted to nursing homes through the "regular" extended care program rather than through the HSC program.

Source: Mental Health Division, Ministry of Health, June 1984.

Both the nursing homes and the residential homes for special care are private, for-profit operations. At least 200 nursing homes provide extended or intermediate care to HSC residents; another 300 residential homes provide custodial supervision to people considered unable to be self-sufficient.[18] Residential homes generally vary in size from 1 to 30 beds although a few homes have over 50 residents. Unlike the HSC nursing homes which are regulated under the Nursing Homes Act, there are no Ministry guide-

18. Tri-Ministry Project in Homes for Special Care and Nursing Homes, Report of the Task Force on Transfer of Responsibility and Rationalization: Developmentally Handicapped Clients in Nursing Homes and Residential Homes for Special Care, Phase I - Issues, Options and Implications, September 15, 1983, p. 5.

lines or staffing standards for residential homes for special care. The operator usually employs no support staff and no qualifications are required of the candidate operator to be eligible for funding under the HSC program.[19]

The per diem payments to operators under the HSC program are: $42.35 for extended care (in nursing homes), $36.04 for intermediate care (in nursing homes) and $18.13 for residential care (in residential homes). Unlike the regular extended care program in nursing homes, there is no co-payment or resident portion in the HSC program. The Ministry of Health pays the total per diem amount for all three levels of care. In 1983/84, Ministry expenditures for the HSC program totalled $85.4 million.[20]

It should be noted that the HSC program has been reviewed by the government several times in the past. A major study has been promised for the fall of 1984. Serious concerns have been raised about the lack of programming for HSC residents and the fact that possible roles for the program (whether custodial, rehabilitative, or social) are not well-defined.[21] Until the fate of the HSC program is decided, a moratorium has been placed on the licensing of new residential homes and a ceiling set on the amount which can be spent on the program.[22]

3.3.3 Rest Homes/Retirement Homes and Boarding Homes

Another area of substantial commercial involvement is in the provision of rest homes/retirement homes and boarding homes. Rest homes/retirement homes are facilities ranging in size from 3 to 300 beds which provide less than 1½ hours per day of care and supervision in a communal environment.[23] There are essentially two kinds of rest homes/retirement homes: those catering to well-to-do elderly people where charges range from $700 to $3,000 per

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19. G.F. Heseltine, Towards a Blueprint for Change: A Mental Health Policy and Program Perspective, Discussion Paper, December 1983, pp. 127-133.
20. Information obtained from the Ministry of Health, March 1984.
21. Heseltine, Op. Cit., p. 132.
22. Tri-Ministry Project, Op. Cit., p. 43.
23. Keith Becker, Design Guidelines for Rest Homes/Retirement Homes, A Study for Canada Mortgage and Housing Corporation, August 1983, p. 3.

month for hotel-style living, including a central dining room, laundry services and, in some cases, a registered nurse available on a stand-by basis;[24] and those facilities which serve some of the most vulnerable segments of the population, such as elderly or handicapped people and ex-psychiatric patients, frequently whose only source of income is a social assistance cheque.

It is not known precisely how many rest homes/retirement homes there are in Ontario. The Rest Home Association of Ontario, which represents about 180 rest homes with a total of more than 6,000 beds,[25] estimates that one-quarter to one-third of all rest homes are members of the provincial association. This means that there may be 450 rest homes in Ontario, with as many as 18,000 to 20,000 beds. A number of rest homes operated as "nursing homes" prior to the introduction of the Nursing Homes Act in 1972. Many of these failed to qualify as nursing homes under the legislation, but continued to "attract vulnerable people under the label of 'rest' homes."[26]

Virtually all rest homes/retirement homes are commercial enterprises, in some cases owned by the same corporations which operate nursing homes. Several companies have begun to build rest homes/retirement homes on the same grounds as nursing homes or hospitals.

Boarding homes are commercial facilities ranging in size from small, family-type settings with 3 to 10 residents to larger-scale operations with 40 or more beds.[27] The terms "rest home", "boarding home", and "lodging house" are often used inter-changeably to refer to adult residential facilities which provide accommodation to people with special needs, but offer no support services or rehabilitative programming. The Association of Municipalities of Ontario defines an "adult residential facility" as

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24. Salem Alaton, "Playing for Time, Ontario's Seniors Need an Integrated System of Care", The Globe and Mail, Saturday, June 9, 1984, p. L1.
25. Information obtained from Rest Home Association of Ontario, March 1984.
26. Municipality of Metropolitan Toronto, Adult Residential Facilities, First Report to the Metro Toronto Social Services and Housing Sub-Committee on Boarding Homes and Lodging Houses, October 1979, p. 7.
27. Ibid., p. 7.

"... a private or commercial facility intended to provide temporary or long-term living accommodation, for compensation, for three or more adult persons not related by blood or marriage to the operators, which offers assistance with activities of daily living ..."[28]

There appears to be even less information on the number of boarding homes in Ontario than there is on rest homes. In Metro Toronto, the only two municipalities which will allow boarding homes are the City of Toronto and Etobicoke. A 1981 report estimated that a third of the beds available to ex-psychiatric patients in Metro Toronto were in boarding homes.[29] In addition to people discharged from psychiatric hospitals, boarding homes provide accommodation to elderly citizens, people with alcohol problems, and handicapped individuals, frequently all under one roof.

Neither rest homes/retirement homes nor boarding homes are provincially funded, licensed or regulated.[30] The only controls which exist over these facilities is through municipal by-laws pertaining to physical standards. However, some municipalities, such as Windsor and Hamilton, purchase domiciliary hostel accommodation funded under the General Welfare Assistance Act from commercial boarding and rest homes. These municipalities have introduced standards of care as conditions of the contract. Hamilton, for example, specifies that operators must provide 24 hour supervision and monitor residents' medication.[31] Metro Toronto's Community Services Department also purchases residential care beds for elderly people from commercial rest homes and boarding homes. Called "satellite homes" these programs are regulated under the Homes for the Aged and Rest Homes Act. As of June 30, 1984, 388 people were living in commercial rest homes and boarding homes under the satellite homes program. Another 45 individuals were in non-profit "satellite homes".[32]

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28. Association of Municipalities of Ontario, AMO Reports 82-1, "Adult Residential Facilities", March 1982, pp. 5-6.
29. Reported in Heseltine, Op. Cit., p. 145.
30. Reva Gerstein, "The Preliminary Report of the Mayor's Task Force on Discharged Psychiatric Patients, Toronto, November 1983, p. 24.
31. Ibid., p. 25.
32. Information obtained from Metro Toronto's Community Services Department, July 1984.

3.3.4 Hospital Management

Two experiments in private hospital management have to date received the approval of the provincial government: American Medical International's (AMI's) contract to manage the Hawkesbury General Hospital near Ottawa and Extendicare's arrangement to build and manage a chronic care wing for the Queensway General Hospital in Etobicoke. Although there are differences between the two situations, they have two significant features in common: the arrangements are with for-profit corporations, and the promise of private capital appears to have been a major reason for the outside management contract.

In August 1982, the Ministry of Health approved the construction of a new hospital in Hawkesbury to be cost-shared between the Ministry and the hospital. The existing Hawkesbury Hospital, however, was incurring annual deficits of $500,000 and experiencing other operational difficulties. In January 1983, it signed a 12-year agreement with AMI to manage the new hospital for a fee of $300,000 a year, in addition to 50 percent of any profits above $750,000.[33] The Ottawa General Hospital, which was already providing consulting services to Hawkesbury, was another major bidder for the contract. The agreement was awarded to AMI, in part at least, because of the corporation's ability to provide a loan guarantee for the $6 million needed to build the new hospital.[34]

In May 1983, the Ministry of Health approved a 20-year arrangement with Extendicare Ltd. to build and manage a 120-bed chronic care hospital at Queensway. Extendicare is paying two-thirds of the $6.5 million capital costs - the portion the Ministry of Health usually contributes to expand or build hospitals.[35] In exchange for providing the capital, Extendicare

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33. "Cutting Hospital Costs", The Toronto Star, Tuesday, October 18, 1983, p. A14.

34. See: "The Hawkesbury Experiment", in Hospital Highlights, Ontario Hospital Association, March/April 1983; and Privatization of Hospitals: The Growing Threat, CUPE Research, Ottawa, February 1983.

35. "Firms Seeking to Manage Hospitals", The Globe and Mail, Report on Business, August 22, 1983, p. B3.

will manage the hospital and will receive per diem payments from the Ministry of Health for both operating and capital costs.[36]

The Ministry of Health has said that there would be no new provincial funds to cover capital costs until 1990; all provincial money has already been committed until then. Therefore, to relieve the government of the need to find capital funding, hospitals are being encouraged to enter into agreements with private firms to expand or build needed facilities.

3.3.5 Visiting Homemaking and Nursing Services

Home support services, such as visiting homemaking and nursing services, have traditionally been offered by voluntary organizations such as the Canadian Red Cross Society and the Victorian Order of Nurses. In the last ten years or so, there has been a noticeable increase in the number of commercial home health care agencies providing services similar to those offered by the voluntary groups. Although precise information on this trend is not available, it is estimated that the number of commercial agencies in Metro Toronto has tripled since 1974.[37]

The reason usually given to account for the growth in commercial nrusing and homemaking agencies is the expansion of provincial government programs, such as the Ministry of Health's Home Care Program. An insured service under the Ontario Health Insurance Plan (OHIP), the Home Care Program is administered in 38 Ontario communities. A variety of in-home services can be provided under this program, including nursing, physiotherapy, occupational therapy, and homemaking (if provided in conjunction with one of the other professional services). To qualify for a service under the Home Care Program, a person must be under the medical supervision of a physician, and have rehabilitative needs which cannot be met on an outpatient basis in a hospital. There are both acute and chronic Home Care Programs with different eligibility criteria and maximum hours of service.

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36. "Hospital Deal Still Makes Sense", The Toronto Star, Nov. 22, 1983, p. A13.
37. Estimates based on agency listings in the Yellow Pages of the Metro Toronto telephone book for 1974 and 1984.

According to Ministry of Health estimates, in 1983/84 the total expenditures for homemaking services purchased by the local Home Care Programs in Ontario amounted to $18.3 million. More that half of the contracts were with commercial agencies,[38] which accounted for 22.1 percent of the expenditures for purchased homemaking services.[39]

In Metro Toronto, seven of the eleven agencies from which the Home Care Program purchases homemaking services are commercial agencies. In 1982/83, purchase of service contracts with the commercial sector amounted to $1.6 million, or 63.2 percent of the Home Care Program's total expenditures of over $2.5 million for purchased homemaking services. The amount spent for services purchased from commercial homemaking agencies has more than doubled since 1978/79.[40] To date, the Metro Home Care Program has no contracts with commercial nursing agencies.

Although some commercial nursing agencies provide visiting nursing services, most serve an institutional or hospital clientele. The private firms which provide nursing services to people in their own homes generally do so only for a complete shift or on 24-hour basis.[41] For this reason, local Home Care programs do not often purchase nursing services from commercial agencies. In 1983/84, commercial agencies accounted for only 6 out of 78 agencies from which Ontario Home Care programs purchased visiting nursing services.[42] However, commercial agencies are beginning to offer visiting nursing services in order to compete for future contracts.

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38. "Estimate of Total Expenditures for Nursing and Homemaking Services per Home Care Program: 1983/84", Sessional Paper No. 109, 4th Session, 32nd Parliament, Tabled May 18, 1984.

39. Information obtained from the Ontario Association of Visiting Homemaker Services, August 1984.

40. Expenditures for Purchased Homemaking Services, Home Care Program for Metro Toronto, April 1984.

41. Review of the Provision of Visiting Nursing Services to the Ontario Home Care Program, Medicus Canada, March 1983, p. 7.

42. Sessional Paper No. 109, Op. Cit.

Visiting homemaking and nursing services can also be purchased by municipalities for eligible persons in financial need. Under COMSOC's Homemakers and Nurses Services Act, the Ministry pays 80 percent of the subsidy, and the municipality the remaining 20 percent. Metro Toronto's Community Services Department is currently purchasing services from only one commercial agency under this legislation. However, this is likely to increase with the introduction of the chronic care program under Home Care. Metro Toronto's Community Services will be subsidizing people who are no longer eligible for the provincial program and will purchase services from the same homemaking agencies, primarily commercial, which have been serving these individuals under Home Care. It should be noted that the Regional Municipality of Peel has decided not to purchase homemaking and nursing services from commercial agencies because of concerns about quality of service and the impact on the voluntary sector.[43]

A 1982 survey of homemaking services found that commercial agencies provided services in only four provinces - Ontario, Alberta, British Columbia, and Newfoundland. Seventy percent of the commercial agencies which responded to the questionnaire were established between 1970 and 1979. A significant difference between the non-profit/governmental and commercial agencies appeared to be in location. While two-thirds of all homemaking agencies served population areas with fewer than 50,000 people, none of the commercial agencies were located in these small service areas. By contrast, three-quarters of the commercial agencies served population centres of 250,000 or more, while only 8 percent of all agencies were located in these large urban centres.[44] Similarly, the highest concentration of commercial home care agencies in Ontario appears to be in the large urban centres.

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43. Conversation with Jim Crozier, Commissioner of Social Services, Regional Municipality of Peel, May 1984.

44. Canadian Council on Homemaker Services, Visiting Homemakers Services in Canada Survey, 1982, pp. 18-19.

3.3.6 Day Care Centres for Children

In 1983, there were close to 1900 day care centres in Ontario, with a total licensed capacity of almost 70,000 spaces.[45] This includes both full and part-time group care provided by municipal, non-profit and commercial centres. In addition, another 5,000 children were in supervised private-home day care settings and an unknown, but large, number were placed in care through informal private arrangements. This discussion is limited to licensed day care centres and does not include either private home day care or informal arrangements.

Day care centres are regulated and licensed under the 1978 Day Nurseries Act of the Ministry of Community and Social Services. However, the legislation does not require the government to provide day care; planning and developing day care centres is assumed to be the responsibility of community initiative.[46] The Act allows municipalities and Indian bands to provide day care services themselves or to enter into purchase-of-service agreements with licensed non-profit and commercial day care centres to provide care for children of families eligible for a subsidy.

The costs of subsidized day care are shared by the federal government (50 percent), the provincial government (30 percent), and the municipal government (20 percent). Ontario is the only province which receives federal cost-sharing for both non-profit and commercial day care centres. The other nine provinces either provide no subsidies to commercial centres or use only provincial funds for this purpose. However, in order to qualify for CAP cost-sharing of commercial centres, Ontario requires parents seeking a subsidy to be needs-tested in a way which is often more onerous than the requirements of other provinces.

In 1982/83, COMSOC's expenditures on day care totalled $75.4 million, $62.7 million for regular programs, $11.2 million on programs for

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45. Information obtained from the Day Nurseries Information Systems (DNIS), Ministry of Community and Social Services, March 1984.

46. Ministry of Community and Social Services, Day Care Policy: Background Paper, October 1981, p. 24.

handicapped children, and $1.5 million on capital costs.[47] Unfortunately, the Ministry keeps no record of what proportion of total expenditures went to the commercial sector.

The following table gives a breakdown of licensed spaces in Ontario and Metro Toronto by the three major types of day care operators.

TABLE 5

LICENSED CAPACITY OF DAY CARE CENTRES BY OPERATOR TYPE, ONTARIO AND METRO TORONTO, 1979 AND 1983

Operator Type[1]	ONTARIO		METRO TORONTO	
	1979	1983	1979	1983
Municipal[2]	8,359 (16.4%)	9,007 (13.8%)	2,282 (13.8%)	2,531 (10.7%)
Non-Profit[3]	16,712 (32.8%)	25,488 (39.2%)	5,839 (35.4%)	11,156 (47.0%)
Commercial[4]	25,827 (50.8%)	30,603 (47.0%)	8,338 (50.7%)	10,040 (42.3%)
TOTALS[1]	50,898 (100%)	65,098 (100%)	16,459 (100%)	23,727 (100%)

1. "Individuals for an Unincorporated Group" have not been included in any of the three operator type categories since it is not known whether these are non-profit or commercial. Total licensed capacity is, therefore, under-represented by about 5,000 spaces in Ontario and 1,100 spaces in Metro Toronto.
2. Includes "Municipal" and "Indian Bands" for Ontario and only "Municipal" for Metro Toronto.
3. Includes "Charitable Corporation", "Approved Charitable Corporation", and "Approved Charitable Handicapped Corporation".
4. Includes "Private Individuals" and "Non-Charitable Corporations".

Source: Day Nurseries Information System, Ministry of Community and Social Services, March 1984.

As Table 5 shows, in 1983 almost half of the licensed day care spaces in Ontario were in the commercial sector, which includes private indi-

47. Information obtained from the Ministry of Community and Social Services, July 1984.

viduals, groups, and corporations operating as for-profit businesses. Although the largest growth since 1979 has been in the non-profit sector, commercial centres still account for 47 percent of the province's total licensed capacity, followed by the non-profit centres with 39.2 percent and municipal with 13.8 percent. The growth pattern is similar for Metro Toronto, with the non-profit sector showing the greatest increase in licensed capacity since 1979 and the municipal the lowest. In 1983, the commercial sector accounted for 42.3 percent of the licensed spaces in Metro Toronto, compared with 47 percent in the non-profit centres and 10.7 percent in the municipal. This represents an increase of 20.4 percent, or 1702 spaces, since 1979 which is slightly higher than the 18.5 percent provincial increase in commercial spaces. Metro Toronto has a lower proportion of commercial spaces to total licensed capacity than the province as a whole because of the large growth in Metro's non-profit sector. In Ontario, the licensed capacity of non-profit centres grew by 52.5 percent from 1979 to 1983, compared with 91 percent for Metro Toronto.

Although the figures presented above include part-day, part-week, and day care for school-aged children, day care is most frequently thought of as a service to working parents. It is, therefore, instructive to look only at the full-time enrollment of pre-school children. Table 6 provides a breakdown by operator type and age categories for children enrolled full day, five days a week.

Table 6 shows that over half, 53 percent, of the pre-school children in Ontario enrolled in day care on a full-time basis were in commercial programs, compared with 27.9 percent in non-profit centres and 19.1 percent in municipal. This is not surprising in view of the fact that non-profit centres offer considerably more part-time than full-time programs.

TABLE 6

DAY CARE ENROLLMENT OF FULL-TIME PRE-SCHOOL CHILDREN
BY OPERATOR TYPE, ONTARIO, APRIL 1984

AGE OF CHILDREN	Number of Children Enrolled			TOTALS[1]
	Municipal	Non-Profit	Commercial	
Infants	51(4.4%)	354(30.3%)	763(65.3%)	1,168(100%)
Toddlers	370(15.1%)	753(30.7%)	1,333(54.3%)	2,456(100.1%)
Pre-School	2,496(16.6%)	4,282(28.4%)	8,275(55.0%)	15,053(100%)
Junior Kindergarten	1,303(29.3%)	1,099(24.7%)	2,043(46.0%)	4,445(100%)
Senior Kindergarten	754(25.4%)	792(26.6%)	1,426(48.0%)	2,972(100%)
TOTALS	4,974(19.1%)	7,280(27.9%)	13,840(53.0%)	26,094(100%)

1. Although the actual enrollment figure is somewhat lower than for previous years, the proportional breakdown is consistent. In both 1981 and 1982, commercial centres accounted for 51.2 percent of the total pre-school, full day enrollment.

Source: Day Nurseries Information System, Ministry of Community and Social Services, April 1984.

Most public funding of day care is used to subsidize spaces for low income families. Therefore, to determine how public money is being spent, it is important to look at the distribution of subsidized spaces among the three operator types.

Table 7 indicates that municipal centres accounted for the highest percentage of subsidized spaces in 1983, 36.6 percent, followed by the non-profit centres with 33.5 percent and the commercial centres with 29.9 percent. However, the recent growth in the number of subsidized spaces has been less in the municipal sector than in either the for-profit or non-profit sectors. The increase of 229 subsidized municipal spaces represents only a 4.1 percent increase since 1979, compared with a growth of 21.7 percent in commercial and 33.1 percent in non-profit centres. This suggests that municipal governments, like their provincial counterpart, are also privatizing social services, at least in the field of day care.

TABLE 7

SUBSIDIZED DAY CARE SPACES BY OPERATOR TYPE
ONTARIO, 1979 AND 1983

Operator Type	Subsidized Day Care Spaces	
	1979	1983
Municipal	5,640 (41.4%)	5,869 (36.6%)
Non-Profit	4,040 (29.7%)	5,380 (33.5%)
Commercial	3,945 (28.9%)	4,802 (29.9%)
TOTAL[1]	13,625 (100%)	16,051 (100%)

1. The total number of subsidized spaces is under-represented. Subsidy data is only collected on renewal forms and does not include centres operating in their first year.

Source: Day Nurseries Information System, Ministry of Community and Social Services, March 1984.

Provincial averages, however, do not always tell the whole story. The following table offers a comparison of the distribution of subsidized spaces by operator type in the four regions of Ontario.

TABLE 8

SUBSIDIZED DAY CARE SPACES BY OPERATOR TYPE,
ONTARIO REGIONS, 1983

Operator Type	Subsidized Day Care Spaces			
	Central	East	North	West
Municipal	2,846 (31.4%)	1,086 (38.3%)	675 (68.2%)	1,262 (39.8%)
Non-Profit	2,825 (31.2%)	1,175 (41.5%)	163 (16.5%)	1,217 (38.4%)
Commercial	3,383 (37.4%)	573 (20.2%)	152 (15.4%)	694 (21.9%)
TOTAL[1]	9,054 (100%)	2,834 (100%)	990 (100%)	3,173 (100%)

1. Total number of subsidized spaces is under-represented.

Source: Day Nurseries Information System, Ministry of Community and Social Services, March 1984.

The Central Region, which includes Metro Toronto and the counties of Peel, Dufferin, Halton, Simcoe, and York accounts for well over half of the total number of subsidized spaces in Ontario. It is, therefore, significant that in this region the largest number of subsidized spaces is in the commercial sector, 37.4 percent, compared with 31.4 percent in the municipal and 31.2 in the non-profit. The other three regions rely much more heavily on the municipal and non-profit centres for the provision of subsidized spaces.

Comparisons of day care provision in other Canadian provinces is instructive. As indicated in Table 9, in 1983, approximately 40 percent of all full-time day care spaces in Canada were in commercial centres. The non-profit sector accounted for 54.1 percent, while the public or municipal sector comprised 5.5 percent.

TABLE 9

INTER-PROVINCIAL COMPARISON OF FULL-TIME DAY CARE SPACES BY OPERATOR TYPE, CANADA, 1983

Provinces	FULL TIME DAY CARE SPACES		
	Public	Non-Profit	Commercial
B.C.	--	5,369 (42.0%)	7,414 (58.0%)
ALTA.	800 (3.5%)	8,112 (35.3%)	14,071 (61.2%)
SASK.	--	2,993 (96.3%)	114 (3.7%)
MAN.	--	6,010 (81.1%)	1,397 (18.9%)
ONT.	6,000 (13.3%)	20,000 (44.3%)	19,193 (42.5%)
QUE.	--	19,775 (82.1%)	4,302 (17.9%)
N.B.	--	1,716 (61.5%)	1,072 (38.5%)
N.S.	--	2,426 (60.5%)	1,580 (39.5%)
P.E.I.	--	172 (55.0%)	141 (45.0%)
NFLD.	--	186 (29.3%)	449 (70.7%)
TOTALS	6,800 (5.5%)	66,759 (54.1%)	49,733 (40.3%)

Source: National Day Care Information Centre, Health and Welfare Canada, 1983.

Looking at individual provinces, it is interesting to observe that Saskatchewan has so few commercial spaces. This is because provincial legislation prohibits for-profit provision of day care and favours parent co-ops. In British Columbia, Manitoba, and Quebec, there are restrictions on purchasing subsidized spaces from commercial centres, although fee-paying parents may choose to place their children in these centres.[48]

3.3.7 Residential Services for Children

There are more than 400 children's community residences licensed under COMSOC's Children's Residential Services Act, with a total capacity of over 4,100 beds. These figures include children's mental health centres, homes for retarded children, children's institutions, observation and detention homes (low and medium security), maternity homes, and residences for young offenders.[49] Although CAS-run residences are also licensed, provincial figures are not available on the number of these homes. Facilities directly operated by the Ministry, such as training schools and provincial mental retardation institutions, are not licensed under the legislation.

Even though all non-governmental children's residences are licensed under the same act, different funding mechanisms apply. Children's mental health centres, for example, receive 100 percent of their operating costs from COMSOC, while the amount which children's and youth institutions receive from the government varies from facility to facility. Commercially-operated children's residences receive no direct operating funds from COMSOC; their services are purchased by other organizations, such as the Children's Aid Societies or Probation and Aftercare offices.

Many of the facilities which are today licensed as children's residences evolved from largely unregulated, privately-run boarding homes for children. The original Children's Boarding Homes Act, passed in 1957

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48. Laura Johnson and Norma McCormick, Day Care in Canada: A Background Paper, Canadian Advisory Council on the Status of Women, Ottawa, August 1984, p. 49.

49. Ministry of Community and Social Services, Child Advocacy Information System, "Number of Facilities and Capacity by Facility Type", Provincial Summary as at March 31, 1984.

in response to a scandal involving a rural Ontario woman who was inadequately caring for more than 80 children, required that homes with five or more unrelated children be provincially licensed and inspected.[50] From these homes have come virtually all of the existing for-profit children's residences. Of the remaining residences, many commercial operators began as foster parents. As they took in more children, they became incorporated and licensed, and are now run as private, for-profit operations. Although most commercial children's residences are of the mom-and-pop variety, there are a number of chain-run operations as well.

Precise information on the number or relative proportion of for-profit children's residences is extremely difficult to obtain because COMSOC does not record the ownership status of operators. However, it is known that most of the children's residences previously under the Boarding Homes Act were run for profit. Estimates, based on a review of a directory of facilities for children, are that in 1976 approximately 36 percent of the 4,200 beds in community residences were operated for profit.[51] The other 64 percent were provided by the non-profit sector. Government-run institutions and CAS-operated residences were not included in the total. Included were children's mental health centres, children's institutions, homes for unmarried mothers, youth institutions, children's boarding homes, homes for retarded persons, and correctional group homes.

As of March 31, 1984, approximately 50 percent of the licensed children's residences were operated for profit, with the remaining half being non-profit. However, because the for-profit homes tend to be smaller than their non-profit counterparts, the commercial sector accounted for only 40 percent of the licensed capacity.[52] It should be noted that, because CAS-operated residences were not included in the totals, the non-profit sector is under-represented.

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50. Lorna Hurl, "Social Services by Government Contract: The Bargain Basement of Welfare", Unpublished paper. Toronto: June 1983, pp. 87-88.

51. Council for Troubled Children and Youth, Directory of Facilities for Troubled Children and Youth, Secretariat for Social Development, December 1976.

52. Child Advocacy Information System, Provincial Summary, Op. Cit.

According to Statistics Canada, in 1983 for-profit residences accounted for approximately 34 percent of all beds in children's residences in Ontario. Table 10 below also shows that the proportion of beds in proprietary residences is almost twice as high in Ontario as in Canada as a whole. When Ontario's beds are subtracted from the totals for Canada, the commercial sector accounts for only 10.7 percent of the total number of beds in the remaining nine provinces, compared with Ontario's 33.8 percent.

TABLE 10

NUMBER OF SPECIAL CARE FACILITIES[1]
AND MAXIMUM BEDS FOR CHILDREN[2]
BY TYPE OF OWNERSHIP,
CANADA AND ONTARIO, 1983

	CANADA		ONTARIO	
Ownership	Number of Facilities	Number of Beds	Number of Facilities	Number of Beds
Proprietary	216 (27.9%)	2,273 (17.9%)	114 (46.3%)	1,344 (33.8%)
Voluntary[3]	316 (40.8%)	4,464 (35.2%)	115 (46.7%)	2,130 (53.5%)
Government[4]	242 (31.3%)	5,951 (46.9%)	17 (6.9%)	505 (12.7%)
TOTALS[5]	774 (100.0%)	12,688 (100.0%)	246 (99.9%)	3,979 (100.0%)

1. "Special Care Facilities" include facilities with 4 or more beds, excluding hospitals.
2. Includes "emotionally disturbed children" and "delinquents".
3. Includes "Religious" and "Lay".
4. Includes "Municipal", "Provincial", "Public Undistributed", and "Federal".
5. Totals for both Canada and Ontario are under-estimated because children may be included in other categories.

Source: Statistics Canada, Inventory of Special Care Facilities, 1983.

The above statistics are supported by referral information from the Children's Aid Society of Metro Toronto. In 1982, 50.6 percent of all

outside placements in group facilities (as opposed to foster care) were made to for-profit residences, compared with 45.6 percent to non-profit and 3.9 percent to government facilities.[53] (It should be noted that number of placements is not equivalent to number of children, since a child may be placed more than once a year.)

Looking at the number of children living in facilities at a particular point in time provides another useful perspective. Table 11 below shows the number of children in the care of the Children's Aid Society of Metro Toronto (CAS), the Catholic Children's Aid Society of Metro Toronto (CCAS), and Probation and Aftercare (PAC) who were living in group facilities on December 31, 1984.

TABLE 11

NUMBER OF CHILDREN IN GROUP FACILITIES BY OPERATOR TYPE, METRO TORONTO, DECEMBER 31, 1981

Operator Type	NUMBER OF CHILDREN						TOTALS	
	CAS		CCAS		PAC			
For-Profit	308	(62.6%)	215	(75.2%)	52	(61.9%)	575	(66.7%)
Voluntary	144	(29.3%)	45	(15.7%)	14	(16.7%)	203	(23.5%)
Government Facilities & Hospitals	40	(8.1%)	26	(9.1%)	18	(21.4%)	84	(9.8%)
TOTALS	492	(100%)	286	(100%)	84	(100%)	862	(100%)

Source: Children's Aid Society of Metro Toronto, Toronto Inventory of Outside Resources, 1981.

The above table shows that, for all three agencies, an overwhelming number of children resided in for-profit residences on December 31, 1981. Overall, 66.7 percent of the children living in group facilities were in for-profit homes, while only 23.5 percent were in non-profit residences, and

53. Children's Aid Society of Metro Toronto, I.P.A.C. Case Analysis System, Referrals Made, 1982 (Chart 8).

9.8 percent were in government facilities and hospitals. The explanation for these figures is found in the fact that children tend to stay longer in for-profit facilities than in non-profit. Therefore, the percentage of children living in the for-profit homes in 1981 is higher than the percentage of placements to that sector in the same year. Both the placement and "in care" figures suggest that, even though for-profit residences account for fewer beds than the non-profit sector, agencies appear to use them more than the non-profit homes.

3.4 An Analysis of the Trends in Ontario

Despite the lack of clarity and apparent inconsistencies in provincial government policy regarding for-profit service provision, the commercial sector's role in Ontario's human services is considerable. A major impetus for the emergence of the commercial sector is the program and policy vacuum being created by increasing government withdrawal from service provision and/or funding. Examples identified in this report include the following:

- The virtual moratorium on the expansion of beds in Homes for the Aged, particularly in municipal Homes;
- No provincial funding until 1990 for capital costs of renovation or expansion of hospitals;
- The decrease in the provincial government's share of funding for both nursing homes and Homes for the Aged, as a proportion of total contributions (Appendix A, Table 2);
- The small increase in municipal day care spaces, compared with the growth of the other two sectors.

In some cases, the problem is not government withdrawal from service delivery; the Ontario government never directly provided many services in the first place. Commercial rest homes and boarding homes for adults are flourishing in the absence of government provision and regulation

because there is a need for services which, at the moment, is not being met elsewhere. Similarly, the nursing home industry came into being because prior to 1972 the provincial government took no responsibility for ensuring that these services were available.

The infusion of government funds for new programs has also acted as an incentive for the development of the commercial sector. A striking example is in the area of home support, one of the few service programs to have grown in recent years. The expansion of the Ministry of Health's Home Care Program appears to have been parallelled by an increase in the number of commercial homemaking and nursing agencies. Some observers feel that the enactment of the federal Young Offenders Act will result in an increase in for-profit children's residences since the legislation calls for greater use of community placements.

Although the number of licensed spaces in commercial day care centres increased by 18.5 percent from 1979 to 1983, the for-profit sector has not grown at the same rate as the non-profit. There are several possible explanations. First, the move to unionize day care staff, which began in 1979, has had in impact on staff salaries, overall costs and, of course, on profits. Second, many day care lobby groups have persistently voiced their concern over quality of care in commercial day care centres. A likely result is increased awareness on the part of parents about alleged differences between commercial and non-profit centres. Third, the Ministry of Community and Social Services released its Consultation Paper on Day Care Standards in 1980. The certainty of improved standards may have acted as a disincentive for the establishment of commercial centres. Finally, the Ministry's Day Care Initiatives Program, introduced in 1981, supported the expansion of the non-profit sector, particularly in Metro Toronto.

Two recent developments suggest that the commercial sector, particularly the large day care chains, may continue to expand in Ontario. In May 1984, it was announced that a new day care centre would be opening in Ajax, operated by Versa Play and Learn Centres, Inc., part of a U.S.-controlled company known for catering food and operating nursing homes. It

is reported that day care sites in Metro Toronto are being explored by the same company.[54] Also in May 1984, Metro Toronto's Commissioner of Community Services recommended that the Department be allowed to enter into purchase of service agreements with four day care centres operated by Mini-Skools (now part of Kinder-Care Learning Centres, Inc.). This decision was made in spite of the fact that initial assessment visits revealed that the centres did not fully meet the necessary criteria.[55]

The area of greatest potential growth for Ontario's commercial sector is in health care. First, health care services appear to be considerably more profitable than social services. It is well known that neither day care centres nor children's residences generate large profits at the moment, particularly not for the small mom-and-pop operators. Nursing homes, by contrast, have profit margins ranging between 10 and 30 percent.[56] Second, our health care system is largely facility-based, which means that a great deal of money is needed for capital costs. As the provincial government becomes increasingly reluctant to finance new or expanded facilities, private business will be asked to step in to provide health services. As evidenced in the United States, the prospect of government spending restraint acts as a clear incentive for increased private sector involvement in human services, particularly in health care. Third, many of the health care companies currently operating in Ontario are firms with substantial holdings in both Canada and the United States. Consequently, they have the financial cushion necessary to allow them to take risks.

Finally, expansion appears to be the goal of most corporations.

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54. "Company Entering Day-Care Business", The Globe and Mail, Wednesday, May 2, 1984.

55. Memo to the Community Services and Housing Committee of Metro Toronto's Community Services Department from Commissioner of Community Services, on "Mini-Skools request for a Purchase of Service Contract", May 1, 1984.

56. See: Sheila Ward, "Private Nursing Homes Find Gold in Caring for the Old", Financial Post, April 14, 1984, p. 26; and Linda McQuaig, "Nursing Homes Flourish Under Taxpayers' Umbrella", The Globe and Mail, May 17, 1984, p. M2.

The largest Canadian nursing home company, Extendicare Ltd., administered almost 9000 beds throughout Canada and had earnings of $24.3 million in 1983.[57] It recently increased its share of the Ontario nursing home market by acquiring the nursing home assets of two competing companies, Ci Kent Corporation and Villacentres Ltd., a move which is estimated to result in annual revenues of $73 million from government and residents.[58] The expansion activities of Extendicare are not unique; in 1983, 41 percent of the nursing home beds were owned by the ten largest companies.[59]

The expansion plans of some corporations are not restricted to the traditional health care fields. Several commercial corporations currently operating nursing homes have set their sights further afield - into the areas of mental retardation services and prisons. Extendicare, for example, is reported to be working with the federal government to investigate the health care needs of prisoners in the Kingston penitentiary. According to Harold Livergant, President of Extendicare, his company can provide the financial and managerial resources which the government is lacking.[60]

The Ontario Nursing Home Association, the provincial lobby group for the nursing home industry, has also proposed a greater role for the private sector in providing services to mentally retarded people. In a submission to a task force examining the Homes for Special Care Program, the ONHA argued that:

> "If the private sector were provided with the same financial basis given to existing public sector facilities for the developmentally handicapped, the private sector would provide quality developmental programs to meet the requirements of the residents, recognizing the financial

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57. Ward, Op. Cit., p. 26.

58. Communique, "Corporate Concentration in Health Care", New Democratic Party of Ontario, November 14, 1983.

59. Ibid.

60. Ward, Op. Cit., p. 26.

resources of the respective Ministries."[61]

Three possible ways of expanding the role of the private sector are proposed: private takeover of public facilities ("private enterprise facilities"); private management-for-fee contracts with public facilities; and management consulting services from private enterprise.[62]

In addition to the above proposals, several of the larger nursing home companies have already begun to move into other health-related services, such as home support, rest homes/retirement homes, and hospital management.

Before examining the major implications and issues in Ontario, it is instructive to look at developments in the United States where commercialization is more pronounced and long-lived than in any other jurisdiction. Although the push to commercial service provision is also taking place in several other Canadian provinces, such as Alberta and British Columbia, as well as in Great Britain, information on the trend is to date very limited. In fact, several recently published British articles on commercialization relied heavily on the American experience for information and analysis.[63] In view of the current dearth of material from other jurisdictions and the extensiveness of commercialization in the United States, it was felt to be both appropriate and informative to describe the American situation in some detail in the following chapter.

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61. Triministry Project in Homes for Special Care, Op. Cit., pp. 62-63.

62. Ibid., p. 63.

63. See, for example: Ken Judge, "The Public Purchase of Social Care: British Confirmation of the American Experience", Policy and Politics, Vol. 10, No. 4 (1982); and Stuart Etherington, "Community Wares on the Private Market", Social Work Today, Vol. 14, No. 37, June 7, 1983.

4.0 LESSONS FROM THE AMERICAN EXPERIENCE

In the United States, proprietary organizations originally emerged in limited sectors, such as day care, residential services for children, and nursing homes to cater only to persons able to pay the full market cost. At the same time, the non-profit agencies took care of those who were unable to pay. The growth of public investment in human services during the 1960's encouraged many for-profit organizations to compete with their non-profit counterparts to provide services to people subsidized by tax dollars.[1]

In the last decade, human services have become big business in the United States, particularly in health care. Small, individually-owned proprietary hospitals, nursing homes, and day care centres are being bought by large corporations whose primary clientele once again are people with ability to pay. The realization that human services can be profitable and the introduction of government social spending restraints have paved the way for an expanded role for the corporate sector, the consequences of which are only beginning to be realized in the United States.

4.1 Accountability, Influence on Public Policy, and Control of the Market

Arnold Relman, the editor of The New England Journal of Medicine, was in 1980 one of the first to voice concern over the growing network of private, for-profit corporations providing health care services previously offered by non-profit organizations.[2] For Relman, a major issue is the possibility that the "medical-industrial complex" could become a powerful political force by virtue of its sheer size and wealth. By 1983, approximately 1100 hospitals, or 15 percent of all general hospitals in the U.S.,

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1. Robert Morris, "Government and Voluntary Agency Relationships", Social Service Review, (September 1982), p. 335.
2. Arnold Relman, "The New Medical-Industrial Complex", The New England Journal of Medicine, Vol. 303, No. 17, (October, 1980), p. 963.

were owned and operated by "investor-owned" (i.e. for profit) corporations.[3] An additional 350 hospitals were managed by for-profit companies.[4] As well, commercial home care agencies, nursing homes, specialty hospitals, and mental health clinics have been expanding at an unprecedented rate.[5]

The fears expressed by Relman and others appear to be well grounded. Both the commercial day care and nursing home industries, which have a longer history than the corporate health care sector, have organized themselves into powerful lobby groups with substantial influence over public policy. The National Association for Child Development and Education (NACDE), which represents 1800 for-profit centres, for several years managed to delay the implementation of new federal day care regulations.[6] Of most concern to the proprietary operators has been the cost implications of standards. A 1977 report revealed that for-profit centres would have to spend 25 to 51 percent more to meet federal standards, compared to non-profit centres which would have to increase expenditures by 4 to 20 percent.[7] In one state, the for-profit operators also objected to a regulation requiring disclosure of financial information.[8]

Nursing Homes

In the nursing home industry, where 75 percent of all homes are run for profit,[9] anti-regulatory sentiment and organized lobbying have been even more pronounced. The industry has consistently and often successfully

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3. Arnold Relman, "Investor-Owned Hospitals and Healthcare Costs", The New England Journal of Medicine, Vol. 309, No. 6, (August, 1983), pp. 370-71.
4. Curtis R. Bergstrand, "Big Profit in Private Hospitals", Social Policy, (Fall, 1982), p. 51.
5. Modern Healthcare, May 15, 1984, pp. 65-135.
6. "Child Care in the 80's - Status Report on For-Profit Child Care", Child Care Information Exchange, January 1981, p. 23.
7. Sharon Kagan, and Theresa Glennon, "Considering Proprietary Child Care", in E.F. Zigler, and E.W. Gordon, (eds.), Day Care: Scientific and Social Policy Issues, Auburn House Publishing Company (Boston: 1982), p. 409.
8. "For Profit Day Care Operators' Objectives to Meeting Day Care Standards," June 1974, p. 1.
9. Jeff Blyskal, "Gray Gold", Forbes, November 22, 1981, p. 80.

fought attempts to impose accreditation or licensing, arguing that self-regulation or "peer review" could bring about needed reforms. However, the AFL-CIO, in a 1977 study of the nursing home industry, concluded that peer review was "inadequate, unworkable, and unacceptable as a substitute for strict government enforcement of standards".[10] The report identified several accountability issues which are attributed to the profit motive, including financial conflicts of interest and unwillingness to disclose financial information. A major recommendation was for enforceable statutes prohibiting conflicts of interest.[11]

In the early 1970's, the U.S. Senate Subcommittee on Long Term Care held a series of public hearings in response to growing concern over abuses in nursing homes. The subsequent report quotes the following observation:

> "... The concomitant of substantial size in business in America is political power. In the hearings held by this panel, various indications were heard of influence upon the state government by the nursing home industry.[12]

Hospitals

In recent years, influence on public health policy has been heightened by the development of multi-institutional hospital systems. Large conglomerates have been replacing independent proprietary and non-profit hospitals at an alarming rate. Paying lip service to free enterprise and pro-competition, the emerging oligopolies have been calling for further de-regulation of the health care system.[13] At the same time, however, American Medical Interna-

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10. AFL-CIO Departments of Community Services, Social Security, Legislation, Public Relations, and Organization and Field Services, America's Nursing Homes: Profit in Human Misery, Report to the AFL-CIO Executive Council, February 1977, pp. 20-21.

11. Ibid., pp. 18-19.

12. Subcommittee on Long-Term Care of the Special Committee on Aging, United States Senate, Nursing Home Care in the United States: Failure in Public Policy, Introductory Report and Supporting Paper No. 1, December, 1974, p. 225.

13. Bergstrand, Op. Cit., p. 53.

tional (AMI), the second largest for-profit hospital corporation, was recently challenged by the federal government for violating antitrust legislation by attempts to reduce competition in California.[14]

The potential for control by corporate interests appears to be greatest in the health care field. As Relman points out:

> "Modern medical practice requires access to hospitals and medical technology and hence medicine, unlike many other professions, requires huge capital investments. Because medical technology demands such large investments, it makes the medical profession vulnerable to control by whoever supplies the capital."[15]

The potential for control creates ethical issues when physicians are employed by, or own equity, in health care corporations. The economic interests of employers may take precedence over the interests of patients, with doctors becoming "double agents". Since for-profit hospitals depend on physicians to refer patients to them, they actively woo and recruit physicians who will send them the "right" (i.e. paying) patients. For example, Humana Corporation, one of the top six companies in the U.S., attracts doctors by offering them reduced rates on office space next to the hospitals, the latest diagnostic equipment, and guarantees of first-year incomes of $60,000. Although physicians are free to send their business wherever they like, they feel beholden to the company and are implicitly expected to make referrals to Humana's hospitals.[16] Doctors are also losing influence because centralized corporate management is more remote and less responsive to the informal power of physicians.[17]

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14. Cynthia Wallace, "AMI Bid Edged Rival out of Market: FTC", Modern Healthcare, July 1982, p. 38.
15. Arnold Relman, "The Power of Doctors", The New York Review of Books, March 29, 1984, p. 29.
16. Gwen Kinkead, "Humana's Hard-Sell Hospitals", Fortune, November 17, 1980, p. 70.
17. Robert Cunningham, "More Than a Business: Are Hospitals Forgetting Their Basic Mission?", Hospitals, Vol. 57, No. 2, January, 1983, p. 89.

For many critics of the new medical-industrial complex, the most serious concern is over the increasing control of the market being exercised by the industry. The following growth strategies are being incorporated from other monopoly sector industries:

- o increasingly centralized management and decision making structures;
- o becoming the sole provider of care, as well as the payment mechanism that finances it;
- o monopolizing the market by progressing from tertiary to primary care; and
- o employing corporate staff specializing in regulation, social action, and policy formation.[18]

Direct ownership of hospitals is only one way in which the corporations have been cornering the health care market. An increasingly popular method is to enter into contract management agreements with hospitals. Forty percent of all investor-owned systems' hospitals are managed rather than owned.[19] The advantages of contract management for the investor-owned corporations include: being able to marshal the support of the administration and trustees of managed hospitals to present industry views to policy-makers and politicians;[20] and becoming the most likely buyers of hospitals when replacement is needed, since managed hospitals are prime acquisition targets.[21]

The for-profit hospital corporations' rise in influence and size has also been achieved by diversifying into other profitable markets such as nursing homes and home care. Because of the corporate chains' easy access to private capital and debt-financing, they have been able to acquire, in addition to hospitals, subsidiary operations which provide services such as facility and master planning, medical equipment and supplies, home health

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18. Bergstrand, Op. Cit., pp. 53-54.
19. William Dowling, "Multihospital Systems Face Growth, Constraints, Unexploited Options", Hospital Progress, Vol. 64, No. 1, January 1983, p. 48.
20. Donald Johnson, and Linda Punch, "Largest Chains Aggressively Increase Market Share in '81", Modern Healthcare, May 1982, p. 70.
21. Montague Brown, "Multihospital Systems in the '80's - The New Shape of the Health Care Industry", Hospitals, Vol. 56. No. 5, March 1982, p. 73.

care agencies, medical diagnostic laboratories, and computerized financial management.[22] Conforming to the corporate model, the new medical industrial complex is characterized by its mammoth size, diversified capital holdings and absentee ownership, all of which create problems for ensuring accountability and limiting control of the market.[23]

Some of the same patterns can be found in the chain-owned day care business, albeit on a smaller scale. Although the chains currently account for less than 10 percent of all commercial day care, the chain industry is growing. In many cases, expansion is not accompanied by increased day care spaces since the chains have, until recently, been buying out smaller proprietors rather than building new centres. For example, of Kindercare's 725 centres in 1982, 167 were acquired from other owners.[24] A major criticism of chain-owned day care is that it is not accountable to the community it serves. Absentee-ownership and centralized management, according to the critics, strip parents of meaningful involvement.[25]

A 1981 investigation of the nursing home industry found that chain-ownership obscured accountability to prospective consumers and their families. Observing that it is often difficult to obtain reliable information about nursing home ownership, the report suggests that this may be a particular problem for consumers "who may not be able to detect from a facility's name or admission contract that it is associated with a chain."[26] Comparative shopping for nursing home services is extremely difficult even in circumstances where there is full disclosure of information. The U.S. Senate Subcommittee on Long-Term Care observed that "there are few commodities on the market that are more of a "blind item" than nursing home care."[27] One

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22. Bergstrand, Op. Cit., pp. 50-52.
23. Ibid.
24. "Drive-In Day Care? Commercial Chains Thrive on Public Cutbacks", Dollars and Sense, November 1982, p. 9.
25. Alice Lake, "The Day Care Business", Working Mother, November 1980, p. 143.
26. Elizabeth Taylor, "Unnamed Nursing Homes Investigation", File No. 7523150, Draft Report Prepared for the Seattle Regional Office, Federal Trade Commission, May 1981.
27. Subcommittee on Long-Term Care, Op. Cit., pp. 219-220.

reason for this, according to the 1981 investigation, is that "the quantity and quality of information provided by nursing home industry members about their own services impede the decision-making process".[28]

Chain-ownership of nursing homes is also reported to create difficulties for enforcement of state regulations.

> "... Enforcement action against one nursing home in a chain normally has no effect upon other facilities within the chain, even for the same violations. Thus, the government pays little or no attention to a corporations's overall performance ... In this sense, the dozens of discrete units that make up nursing home enforcement efforts are no match for the sophisticated inter-state business practices of many large nursing home chains."[29]

4.2 Costs and Efficiency

Lower costs and greater efficiency head the list of the putative benefits of proprietary service provision. For profit organizations, it is argued, take advantage of economies of scale, high volume, centralized management, marketing, and planning and keeping labour costs low. While it is true that the proprietary sector, particularly the large chains, employs these strategies, the evidence in support of lower costs and greater efficiency is mixed and far from conclusive.

Hospitals and Nursing Homes

Recent studies examining the relative costs in for-profit and non-profit hospitals all showed that both costs to patients and operating expenses

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28. Taylor, Op. Cit., pp. 59-60.
29. Ibid., p. 7.

were higher in for-profit hospitals. Information for 1981 from the Florida Hospital Cost Containment Board found that charges for patient care were 15 percent higher, and operating expenses were 4 percent higher in the proprietary hospitals than in the voluntary hospitals.[30] A similar study of hospitals in California, Florida, and Texas also revealed that charges per day and per admission were substantailly higher, 23 and 17 percent respectively, in the for-profit hospitals.[31] To compensate for their higher costs, the proprietary hospitals were found to charge considerably more for ancillary services than non-profit hospitals. These findings are supported by a California study which found that the for-profit hospitals not only charged more for ancillary services, but also administered more of the profitable services, such as clinical lab test and pharmaceuticals, than did the non-profit hospitals. There was little or no difference in the two types of hospitals in the use of unprofitable services. These observations led the researchers to conclude that the results:

> "... lend credence to concerns that the tension between profit maximization and medical appropriateness may lead to different styles of medical practice in these hospitals."[32]

The for-profit hospitals fared no better in terms of administrative cost efficiency. In the Pattison/Katz study, fiscal and administrative costs, which included home office expenses, were 37 percent higher in the for-profit hospitals. The researchers interpreted these results to mean that "... the data do not support the claim that investor-owned chains enjoy overall operating efficiencies or economies of scale in administrative or fiscal services."[33] Lewin et al's conclusions are similar regarding the lack of administrative efficiency of the for-profit hospitals, although they

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30. Relman, 1983, Op. Cit., pp. 370-371.

31. Laurence Lewin, Robert Derzon, and Rhea Margulies, "Investor-Owned and Nonprofits Differ in Economic Performance", Hospitals, July 1, 1981, pp. 52.54.

32. Robert Pattison, and Hallie Katz, "Investor-Owned and Not-for-Profit Hospitals: A Comparison Based on California Data", The New England Journal of Medicine, Vol. 309, No. 6, August 1983, pp. 350-352.

33. Ibid, p. 352.

acknowledge that the investor-owned hospitals "appear to be achieving some management economies in the use of personnel and physical assets."[34] In other words, the for-profit companies keep labour costs down and own newer buildings than their non-profit counterparts.

In the case of nursing homes, there does appear to be support for the claim of lower costs in the for-profit homes. However, it is not clear whether this is due to greater efficiency or because of cost savings at the expense of service quality and staff costs.

In an examination of the Ohio nursing home industry, where 74 percent of the homes are for-profit, quality was assumed to be identical. The study found that proprietary homes provided care at an average total per diem cost which was $3.92 less than voluntary homes and $9.14 less than government homes. The researchers noted, however, that the for-profit homes saved most money in the direct cost areas where the impact on quality of care is potentially the greatest. They suggested that "... additional data on patient mix and quality would be necessary to provide any definite conclusions."[35] An earlier study of the cost of nursing home care also found that non-profit homes appeared to be more costly than for-profit nursing homes, but only in states with flat-rate reimbursement (i.e. a flat rate paid per patient day regardless of actual cost).[36] Interestingly, the Caswell/ Cleverly study also found that important economies of scale did not exist in the nursing home industry. An increase in the number of beds in a facility did not necessarily lead to a decrease in average cost.[37]

There are reasons to doubt that chain ownership of nursing homes results in cost savings for either consumers or the government. The Ohio Nursing Home Commission found in 1979 that management and administration

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34. Lewin et al., Op. Cit., p. 58.

35. Robert Caswell, and William Cleverly, "Cost Analysis of the Ohio Nursing Home Industry", Health Services Research, 18:3 Fall 1983 , p. 373.

36. H.E. Frech, and Paul B. Ginsburg, "The Cost of Nursing Home Care in the United States. Government Financing, Ownership, and Efficiency", in J. van der Gaag and M. Perlman (eds.), Health, Economics, and Health Economics, North-Holland Publishing Company, 1981, pp. 75-77.

37. Caswell and Cleverley, Op. Cit., p. 368.

costs were higher for chains than for individually-owned nursing homes.[38] Chains must allocate funds to central administrations and to cover lease-sale arrangements, costs which single proprietors do not incur.

Day Care

Despite some disagreement over the value of nursing home cost studies, they do at least offer a starting point for a discussion of cost and efficiency.[39] By contrast, there appear to be few similar studies of these issues in the day care field. In one frequently cited study, the characteristics of different kinds of day care centres were examined. A four-way classification was developed on the basis of legal status (profit or not-profit) and by whether or not centres enrolled publicly-subsidized children. The study found that the highest cost, in terms of average expenditure per full-time child, was associated with the non-profit subsidized centres and the lowest with the profit non-subsidized centres. There was no difference between the non-profit non-subsidized and the profit subsidized centres. The researchers suggested that these differences were the result of variations in services provided, staff/child ratios, and salary scales.[40]

Both the opponents and supporters of for-profit day care acknowledge that operating costs are less in the commercial centres. While the critics claim this is due to sacrificing quality and underpaying staff, industry spokesmen argue greater efficiency. According to one commentator:

> "Proprietary day care companies tend to run their operations in much the same high-volume, low cost fashion that McDonald's does its hamburger stands. In fact, business got into day care in the late

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38. Reported in Taylor, Op. Cit., p. 6.

39. William Scanlon, and William Weissert, "Nursing Home Cost Function Analysis: A Critique", Health Services Research, 18:3 (Fall 1983) pp. 377-379.

40. Richard Ruopp et al., Children At the Center, Summary Findings and Their Implications, Final Report of the National Day Care Study, Vol. 1, Cambridge: Mass., Abt Associates, March 1979, pp. 218-219.

> sixties when it appeared that franchising - which was cleaning up with fast-food, car-repair, nursing home, and mini-golf operations - would be a good model for day care."[41]

Unlike their successful fast food counterparts, most of the franchise day care operations were plagued by problems of mis-management, exploitation, and poor quality services;[42] many lasted only two years before they went into bankruptcy or consolidation.[43] A major reason for the spectacular failure of day care franchising, where the centres are separately owned and operated, was the difficulty in retaining control and monitoring quality. Since the franchised centres were accountable to neither a community board nor a centralized management, there were many opportunities for poor quality and badly-managed operations. The businesses which survived, such as Kindercare, have moved from franchising to chain ownership. The advantages of this approach include: centralized control over costs, quality, and working conditions and the opportunity for diversifying into more profitable, related areas, such as toys and children's clothing.[44]

There is no doubt that, judged as businesses, the existing day care chains are successful. Their goals of growth and expansion are being met and many chains are branching out into other profitable products, including life insurance for toddlers.[45] Their success depends, to a large extent, on keeping labour costs low and aggressive marketing. Consequently, as one commentary observes:

> "... the chains find it necessary to spend money in areas where non-profit centers don't - promotion and advertising, lobbying and expansion. A

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41. Joyce F. Goldman, "From the Folks Who Brought You Fast Food, Nursing Homes, and Minigolf ... Vacuum-Packed Day Care", Ms. Magazine, March 1975, p. 81.
42. Dollars and Sense, Op. Cit., p. 8.
43. Flora Ling, "Baby-Sitting is Big Business", Forbes, July 24, 1978, p. 80.
44. Dollars and Sense, Op. Cit., p. 8.

> 1972 study showed that one commercial chain spent as much on advertising in that year as would have paid for 39 full-time scholarships for fifty weeks.[46]

It is questionable whether corporate success and profitability can be equated with efficiency. There is a conspicuous absence of literature on the small, mom-and-pop commercial operations and we know of no studies comparing efficiency in for-profit and non-profit day care centres. Therefore, claims that commercial centres are more efficient are, despite the fact of lower costs, probably merely speculative.

Residential Services for Children

Even less information is available on for-profit residential services for children. There is apparently a wide discrepancy in the fees charged by commercial organizations, ranging from the very highest to the very lowest rates.[47] Unfortunately, there is no data explaining these differences nor relating costs to outcome. However, problems appear to stem from the fact that in proprietary care:

> "The fiscal operations are extremely unclear ... There is no duly elected administrative board to control business and professional operations. (Some of the so-called boards are really composed of relatives and friends who may have a financial interest in the organization.) Some group homes, for instance, pay substantial per capita 'management fees' to the central office of the proprietor for which they get little in return."[48]

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46. Ibid.
47. M.F. Mayer, L.H. Richman, E.A. Balcerzak, Group Care of Children, Crossroads and Transitions, Child Welfare League of America, Inc. (New York; 1978), p. 211.
48. Ibid., p. 214.

Despite the lack of information about the operations of proprietary children's residences, they are becoming strong competitors for contracts with child welfare agencies. A 1977 study found that 51 percent of the residential treatment services for children were purchased from for-profit organizations.[49] One commentator suggests that the growth in the commercial sector's involvement in providing residential care for children demonstrates "... that the for-profit organizations are able to provide selected social services at a price and quality acceptable to the standards of many local welfare departments."[50]

4.3 Quality of Service, Access, and Responsiveness to Need

The most hotly debated and probably least researched area is the impact of for-profit service provision on quality of service. Actual studies are rare, since researchers appear to find it difficult to identify goals and measure outcomes in human services. There seems to be no agreement that measures, such as staffing levels and client satisfaction, adequately reflect quality. This is not to suggest that there is no evidence to support claims about quality. However, much of it is either anecdotal or relies on indirect indicators of quality.

Day Care

The issue of quality of service appears to be most controversial in the day care field. The commercial chains have been accused of producing "Kentucky fried children" who learn conformity, submissiveness, passivity and hostility.[51] Critics argue that centralized, pre-packaged programming does not allow for flexibility and responsiveness to the needs of individual children. Because the commercial centres pay their staff notoriously low

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49. Reported in Catherine Born, "Proprietary Firms and Child Welfare Services: Patterns and Implications", Child Welfare, Vol. LXII, No. 2, March/April, 1983, p. 109-111.

50. Ibid., p. 115.

51. Dollars and Sense, Op. Cit., p. 11.

wages, staff turnover appears to be a greater problem than in non-profit centres.[52] The argument that low wages, poor staff morale, and high turnover are likely to affect the quality of service in a day care centre is indeed compelling. A 1974 study found that the cost-cutting measures employed by the chain-owned proprietary centres seriously affected the quality of care. Because staff received no paid breaks, were paid poorly, and were threatened with layoffs when enrolment declined, morale was poor and turnover was high, even from month to month.[53]

The Ruopp et al study found that non-profit centres pay their staff better than commercial centres, that the frequency of parent participation is much lower among commercial centres, and that the average non-profit centre has more staff and volunteers than for-profit centres. The non-profit centres were also more likely to offer support services than the commercial centres, which may account for higher operating costs. The difference here, however, was most dramatic between the non-profit centres with federally subsidized children and the commercial centres with no federal subsidies.[54]

The study also showed that the commercial centres clearly catered to the middle class and were generally not interested in serving low-income people. Only 37 percent of the commercial centres served people with incomes below $6,000 a year, compared with 69 percent of the non-profit centres. By contrast, 73 percent of the for-profit centres served people with incomes above $15,000, while only 36 percent of the non-profits catered to parents in this income category.[55] While non-profit centres were frequently set up in inner-city areas to serve a range of ethnic and income groups, commercial centres deliberately located in suburban or "prime market" areas with a high employment rate, above average parent educational levels, and a high percentage of children under six years of age.[56] This marketing strategy has resulted in an uneven distribution of for-profit centres. A disproportionate number are located in the South and Southwest where real estate costs are low

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52. Myron Magnet, "What Mass-Produced Child Care is Producing", Fortune, November 28, 1983, p. 162.
53. Kagan and Glennon, Op. Cit., p. 408.
54. Ruopp et al, Op. Cit., pp. 206-212.
55. Ibid., p. 200.
56. Ling, Op. Cit., p. 82.

and state regulation is generally lax.[57]

Commercial day care executives are reported to operate on the assumption that their customers want convenience, low cost and quality - in that order.[58] Many centres are open for twelve hours, accept all age groups and offer all-day, after-school and summer programs. Centres are generally located on the right-hand side of expressways to eliminate the need for left-hand turns; some chains even offer "drive-in" day care so that parents will not have to get out of their cars. In terms of convenience, for-profit centres seem to be very responsive to need.

Standardization of physical setting and programming characterizes most chain-owned day care centres. According to one commentator: "the bigger the chain, the more pre-packaged the education tends to be".[59] Although corporate-run day care is more impersonal than other day care centres, it is argued that this is what some parents prefer.[60]

Although little is known about the quality of care in proprietary children's residences, they do offer the advantage of flexible intake policies. It has been suggested that this is because "proprietary agencies are not bogged down by as many boards or committees [as voluntary organizations]."[61] Many commercial agencies are apparently willing to take every child, in part because the fee-paying market has been declining and beds must be filled.

Nursing Homes and Hospitals

In the health care field, there is an equal dearth of empirical studies concerning quality of service. However, particularly in the nursing home industry, there is substantial anecdotal evidence suggesting that quality

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58. Dollars and Sense, Op. Cit., p. 9.
59. Ibid., p. 11.
60. Lake, September 1980, Op. Cit., p. 32.
61. Mayer, Richman, Balcerzak, Op. Cit., p. 211.

suffers in for-profit homes. Much of the testimony before the U.S. Senate Subcommittee on Long-Term Care in the early 1970's centred on the deplorable conditions in nursing homes. The problems included: poor treatment of patients; deliberate physical injury, unsanitary conditions, unnourishing or poorly prepared food, over-use of drugs, improper use of restraints, assaults on human dignity, neglect of eye and dental care, profiteering, and mis-appropriation and theft.[62] The committee concluded that at least 50 percent of the nursing homes were so sub-standard as to be life-threatening. (An earlier investigation led by consumer advocate, Ralph Nader, estimated that 80 percent of the homes fell below minimally acceptable standards). The AFL-CIO investigation revealed that most of the abuses relating to patient care took place in the for-profit nursing homes.[63] In addition to concerns about quality of care, the Subcommittee hearings also frequently heard the argument that profit-making acts as an incentive to keep beds occupied and runs counter to the goal of returning people to the community as soon as possible.[64]

More recently, studies have shown that proprietary forms of ownership may be disproportionately represented among the worst quality of care cases. It has been suggested that non-profit ownership, on the other hand, seems to offer protection against very low quality services.[65]

The Federal Trade Commission's 1981 report observed that chain control, in particular, may affect the quality of services provided. Two characteristics of for-profit nursing home chain operations were identified as being important:

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62. Subcommittee on Long-Term Care, Op. Cit., pp. 169-208.

63. AFL-CIO Report, Op. Cit., p. 18.

64. Subcommittee on Long-Term Care, Op. Cit., p. 225.

65. Reported in "Does the Non-Profit Form Fit the Hospital Industry? - A Dialogue", Program on Non-Profit Organizations, Institution for Social and Policy Studies, Yale University, Research Reports, No. 3. (Fall 1984), p. 6.

> "... Major budgetary and procedural decisions for individual nursing homes are usually made from a distance, via the corporate office. Chain managers may be less concerned than local operators about their reputations, especially in communities experiencing bed shortages and high demand. The second is that large corporations are likely to view nursing homes first as businesses, second as health care institutions. This lends itself to centralized management decisions that may maximize profits at the expense of care."[66]

Several studies have confirmed that for-profit nursing homes cut costs at the expense of staff salaries and services to patients, such as nursing and dietary services.[67] This is consistent with the pattern in for-profit hospitals, where considerably less money is spent on nursing services than in non-profit hospitals.[68]

Unfortunately, virtually all of the recent studies comparing for-profit and non-profit hospitals deal only with cost and efficiency. Statistical evidence regarding superiority in terms of quality is rare. Yet, one study conducted in the 1960's found that 85 percent of patients treated in voluntary teaching hospitals received optimal care, compared with only 47 percent of those admitted to proprietary hospitals.[69] Furthermore, information from the Federal Department of Health, Education, and Welfare revealed that for-profit hospitals tend to treat less seriously ill patients, and to provide fewer services than the non-profit and government hospitals.[70] Since

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66. Taylor, Op. Cit., p. 6.
67. Caswell and Cleverley, Op. Cit., p. 374; Frech and Ginsburg, Op. Cit., p. 77.
68. Lewin et al., Op. Cit., p. 55, Bergstrand, Op. Cit., p. 77.
69. Reported in Amitai Etzioni, Social Problems, Prentice-Hall, (New York: 1976), p. 121.
70. Ibid., p. 120.

both of these studies were conducted before the advent of the large, corporate chains, the findings should be applied cautiously to the contemporary health care industry.

Morbidity and mortality rates are frequently used as rough indicators of success in health care. However, these would clearly be inadequate measures of quality of care in hospitals. Some experts, in fact, feel that the health field so lacks ways of measuring quality, that "any statement on either side of the profit/non-profit issue is nothing more or less than opinion."[71] Nevertheless, Relman argues that there is a danger in:

> "... the tendency of the profit-making sector to emphasize procedures and technology to the exclusion of personal care. Personal care, whether provided by physicians, nurses or other health care practitioners, is expensive and less likely to produce large profits than the item-by-item application of technology ... Just as pharmaceutical firms have tended to ignore "orphan" drugs, i.e. drugs that are difficult or expensive to produce and have no prospect of a mass market, the private health-care industry can be expected to ignore relatively inefficient and unprofitable services, regardless of medical or social need."[72]

Although for-profit hospitals sometimes profess to provide better services, the only evidence for this is at the level of amenities. For-profit hospitals are generally newer than their aging non-profit counterparts. Also, as in the commercial day care industry, the for-profit hospital corporations devote considerable time and expense to marketing their products. Consequently, they frequently offer attractive surroundings, carpeted rooms, and some innovative features, such as "alternative birth centres" where

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71. "The Big Business of Medicine", Newsweek, October 31, 1983, pp. 71-73.
72. Relman, 1983, Op. Cit., p. 65.

fathers can help with delivery and care.[73] One enterprising corporation, Humana Inc., advertises and sends out Insta-Care cards to financially secure people; card carriers are promised fast treatment in emergency situations. The program was established after market research found that people judge a hospital largely by its emergency care.[74]

Many critics of the for-profit health care sector are also alarmed at the increasing commercialization of non-profit hospitals, arguing that such hospitals are forgetting their basic mission.[75] Their criticism is directed at those non-profit hospitals which have begun to emulate the investor-owned chains by reorganizing into multi-institutional systems and engaging in equally aggressive marketing strategies. The defenders of the non-profit system, however, argue that an important difference is that the money generated by the non-profit hospitals stays in the system and is re-invested in new ventures.[76] Furthermore, unlike the for-profit hospital conglomerates, the non-profit hospital systems do not restrict themselves to profitable service provision. For example, while several investor-owned companies are discontinuing management contracts with smaller, unprofitable hospitals in favour of acquiring more profitable nursing home companies, the non-profit sector has been willing to offer management services to small, unprofitable clients.[77]

The non-profit multi-hospital systems also differ from the investor-owned chains in that they are more concerned about offering a range of health services in one geographic area, rather than building up national businesses.[78] This approach offers the promise of greater continuity and comprehensiveness than is being achieved by the for-profit hospital systems, which are generally

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73. Newsweek, Op. Cit., p. 75.
74. Kinkead, Op. Cit., p. 76.
75. Cunningham, Op. Cit., p. 90.
76. S.G. Kernaghan, "Nontraditional Revenue", Hospitals, Vol. 56, No. 23, December 1982, p. 79.
77. Johnson and Punch, Op. Cit., p. 76.
78. Ibid.

geographically dispersed across many states.[79]

For-profit firms have also in recent years entered the home health care field. However, only 20 states have allowed them to participate in the government-funded Medicare and Medicaid programs because of concerns about service quality. The traditional non-profit nursing and homemaking agencies claim that the commercial companies merely provide low-skilled aides for jobs like cooking and cleaning and are not qualified to provide professional care and needs assessment. The proprietary firms, of course, retort that they can provide the same services more cheaply and efficiently. Little appears to be known about the relative merits of these conflicting claims. However, according to one commentary, the federal government "is keeping a watchful eye on the whole industry."[80] The Community Service Society of New York is said to have opposed certification of commercial home health care agencies because reports from other states revealed that these organizations seldom located in under-serviced areas and had engaged in dubious practices.[81]

The most serious charge against the proprietary health care industry, particularly the for-profit hospitals, is that they engage in "cream skimming" and "dumping". Cream skimming is the practice of explicitly or implicitly selecting the most profitable patients. The strategies hospitals can use to accomplish cream skimming include: recruiting only physicians with financially secure practices and patients; locating in affluent areas with few uninsured, poor, or Medicaid patients; and denying all but emergency services to those unable to pay.[82] Another form of cream skimming is the elimination of unprofitable, albeit necessary, services.[83] Dumping is the practice of transferring patients who are uninsured or publicly-sponsored (i.e. Medicare or Medicaid) to other hospitals. Dumping is also known as "transfers

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79. Montague Brown, "Systems, Commerce and the Caring Tradition, Hospital Progress, Vol. 64, No. 5, May 1983, p. 73.
80. "Humana's Hopes", Forbes, September 1, 1977, p. 27.
81. Reported in Rubenstein, Mundy, Rubenstein, Op. Cit., p. 125.
82. Pattison and Katz, Op. Cit., p. 27.
83. Relman, 1980, Op. Cit., p. 968.

of patients for economic reasons", "demarketing of services", and "management of patient mix".[84]

There is evidence that the for-profit hospitals engage in various cream-skimming activities. Most of the investor-owned hospitals, like their commercial day care counterparts, are located in the affluent suburbs in the Sunbelt states where regulation is relatively light.[85] Humana, for example, establishes its hospitals where there are young working families with children, a group which is likely to be insured. Otherwise healthy, these prospective patients may need only routine operations which can be quickly and efficiently treated. In the words of one observer:

> "By attracting young, privately-insured customers, Humana lowers the chance of having to deal with multi-systemic or chronic diseases like leukemia or cancer that are four of five times more expensive to treat than a hernia.[86]

Many for-profit hospitals are known for their aggressive recruitment of physicians who are likely to refer profitable patients to the hospitals. According to some critics, physicians working for Humana are audited every month to determine how much profit they are making for the hospital. If they are found wanting, their staff privileges are withdrawn and they are encouraged to leave.[87]

Relman identifies another type of cream skimming which for-profit hospitals practice: whether intentional or not, the proprietary hospitals offer virtually no residency or other types of educational programs. Relman suggests that this may be due to the fact that "teaching programs are expensive and often oblige hospitals to maintain services that are not

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84. Emily Friedman, "The 'Dumping' Dilemma: The Poor are Always with Some of Us", Hospitals, Vol. 56, No. 17, September 1982, p. 51.
85. Bergstrand, Op. Cit., p. 49.
86. Kinkead, Op. Cit., p. 70.
87. Bergstrand, Op. Cit., p. 50.

economically viable, simply to provide an adequate range of training experience."[88]

The evidence in support of the claim that for-profit hosptials are more inclined to "dump" certain unprofitable patients onto other hospitals is less compelling. In fact, according to one commentator, both non-profit and proprietary hospitals engage in this practice to a significant degree. The difference may be that investor-owned hospitals are far more explicit about their transfer policies than non-profit institutions.[89] However, it is significant that non-profit hospitals appear to be more willing to accept transferred patients. A California study showed that publicly-owned hospitals received the most transferred Medicaid and "medically indigent" patients, 38.6 percent, while the non-profits treated 36.3 percent of these patients and the for-profit hospitals only 14.1 percent.[90]

The effects of these patterns are serious. A two-tiered system of health care has emerged in the United States, with access severely limited to uninsured, publicly-insured, and medically-complex patients. The burden of caring for these groups is increasingly falling on the non-profit and public hospitals which, according to Relman, "have community obligations and are frequently located in areas where there are many welfare patients."[91] Critics charge that equality of treatment and access are being profoundly undermined by the practices of the investor-owned chains. The corporations argue that these criticisms are unfounded and that the non-profit hospitals also employ some of the same strategies.

Correctional Services

The commercial sector's newest venture is into the field of corrections. Several private companies, including such well-known firms as

88. Relman, 1980, Op. Cit., p. 968.
89. Friedman, Op. Cit., p. 53.
90. Ibid., p. 53.
91. Relman, 1980, Op. Cit., p. 868.

RCA, first became involved in prisons in the mid 1970's by providing medical, educational, or food services on a contract basis.[92] Seen "as the cutting edge of a whole new industry",[93] for-profit prisons now exist in a dozen American communities, with another 20 states currently negotiating private financing, ownership, or managment arrangements.[94] Faced with prison overcrowding and rising inmate populations, government administrators are welcoming private enterprise alternatives to public financing and provision.[95]

Critics of the for-profit prisons are concerned that cost-cutting will be achieved at the expense of prisoners. The companies argue, however, that they can save money by building more cheaply than the government and by reducing labour costs through the use of non-unionized staff.[96] A question raised by civil rights lawyers is whether it is appropriate for institutions other than the state to deprive citizens of their liberty.[97] Some observers also predict that once a community becomes dependent on private enterprise to house prisoners, its bargaining power at negotiations with private firms will be severely limited. Finally, it is being argued that private financing of prisons may prove to be more expensive to the community, since the advantages of this form of privatization do not lie in its cost, but rather "in its circumvention of debt financing and public approval".[98]

Interestingly, the private sector has previously been involved in prisons in both Canada and the United States. During the nineteenth century, private entrepreneurs used inexpensive inmate labour to produce a variety of goods to be sold on the open market for private gain. According to one commentator, "it was ... a conflict between profit and rehabilitation that led to overt exploitation of prison inmates and the eventual abandonment of private contractors in the late 1800's and early 1900's".[99]

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92. Kevin Krajick, "Punishment for Profit", Across the Board, March 1984, p.22.
93. Ibid.
94. "The Corporate Warden", Newsweek, May 7, 1984, p. 80.
95. Krajick, Op. Cit., pp. 21-22.
96. Robert Block, "Private Sector Prisons", Maclean's, Sept. 10, 1984, p. 46c.
97. Krajick, Op. Cit., p. 23.
98. Jean Rosenberg, "Who Says Crime Doesn't Pay?", Jericho, National Moratorium on Prison Construction, Washington, D.C., Spring 1984, No. 35, p.4.
99. Ernie S. Lightman, "The Private Employee and the Prison Industry", The British Journal of Criminology, Vol. 22, No. 1, (January 1982), pp. 37-42.

5.0 ISSUES AND IMPLICATIONS FOR ONTARIO

Although there are some significant differences in human service provision between Ontario and the United States, there are indications that Ontario is experiencing a similar phenomenon which may entail many of the same problems. While the existence of a universal health insurance scheme will probably prevent the emergence of the most blatant barriers to accessible health care, in several other important respects Ontario's situation approximates that of the United States. We have a provincial government committed to social spending restraint, reliance on the private sector as the engine of economic recovery, and a residual, "safety net" approach to social welfare; we have a large non-governmental human service sector which is fragmented, poorly coordinated and planned, and generally inadequately funded; and we are experiencing a growing demand for human services which the government is increasingly unable or unwilling to meet. In combination, these factors are setting the stage for an expanded role for the commercial sector in Ontario's human services. It will be some time before the full implications are understood. Nevertheless, even now there are clear indications that closer attention must be paid to this trend if future problems are to be avoided.

5.1 Lack of Accountability

Nursing Homes

Nowhere are problems of accountability illustrated so clearly as in the nursing home industry. Nearly all of Ontario's nursing homes are private businesses. Although some similar services are provided in municipal and charitable Homes for the Aged, these sectors have not grown at the same rate as the proprietary nursing homes. Yet, people wishing to enter a nursing home must wait 6 to 12 months for a vacancy. The consistently high demand for beds and the limited alternatives to nursing home care have

created a situation in which there is virtually no competition among owners.[1] This is ironic since most of the alleged benefits of privatization are believed to stem from competition among service providers. The nursing home industry acknowledges this lack of competition, but suggests that "... the nursing homes' code of ethics must take the place of the competitive force".[2]

Problems of accountability are reinforced by the lack of competition. As the Concerned Friends of Ontario Citizens in Care Facilities point out:

> "The consumer cannot just pack up and find a better nursing home. At present, old people in Ontario who truly require placement are at the mercy of private owners who enjoy a virtual monopoly ... Demanding accountability creates problems if there is nowhere else to put the residents who suffer when a badly run home closes and they must be transferred en masse."[3]

The lack of alternatives has meant that complaints from residents to nursing home administrators are uncommon. Until recently, there has been no formal grievance procedure and residents are not provided with a statement of rights when they enter a home. It has been suggested that nursing home residents are not likely to complain because they fear reprisals. Daniel Baum, in his 1977 study of the nursing home industry, stated that:

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1. Elaine Newman, "Advocacy on Behalf of Nursing Home Residents," Advocacy Resource Centre for the Handicapped, Toronto, April, 1983, p. 3.
2. Ontario Nursing Home Association, "Report on the Role of Nursing Homes and a Fair and Equitable Funding Methodology," Touche-Ross and Partners, August 1982, p. C-2.
3. Concerned Friends of Ontario Citizens in Care Facilities, "Consumer Concerns and Recommendations Related to Nursing Home Care in Ontario," A Brief to the Honourable Larry Grossman, Minister of Health, September 1982, p. 54.

> "... in confidential talks with Ontario inspectors the point was made that residents are seldom interviewed concerning any complaint. 'The residents are not free to talk to us.' They are too frightened to do so."[4]

Nursing home residents who complain may be the subject of a transfer notice which means they may be transferred or discharged from the facility with only 24 hours' notice. Neither the resident nor his/her relatives are required to consent to important decisions such as plan of care and discharge.[5] Several organizations have recommended that nursing home residents should have access to individual advocates, particularly in situations where there is no ongoing family involvement.[6] However, because nursing homes are private businesses rather than public institutions, trespass laws may be invoked by the nursing home operator. Although the status of residents is protected under the Nursing Homes Act, visitors, doctors, family, and advocates must respect private property rights in nursing homes.[7]

Lack of accountability to residents is also apparent in decisions to sell licenses and build new facilities. Nursing homes are not necessarily located on the basis of responsiveness to need, but rather on the basis of profitability resulting from economy of scale. Instead of being able to remain in the towns and neighbourhoods where they have spent their lives, residents may be forced to move to locations which can support more profitable facilities.

Although nursing homes are inspected by Ministry of Health staff, the present inspection process appears to be inadequate. The identified shortcomings include:

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4. Daniel J. Baum, Warehouses for Death: The Nursing Home Industry, Burns and MacEachern, Toronto, 1977, p. 68.
5. Newman, Op. Cit., p. 3.
6. See: Newman, Op. Cit., and Concerned Friends of Ontario Citizens in Care Facilities, Op. Cit.
7. Newman, Op. Cit., p. 15.

- inadequate staffing (32 inspectors for 332 homes);[8]
- predictability of inspections (nursing homes are practically always informed of when inspections will take place);[9]
- only annual inspection reports, which do not include complaints investigations, are made available;[10]
- confidentiality in complaint filing is not guaranteed.[11]

The accountability of nursing homes to the general public and to government is obscured by the lack of information regarding ownership and financial interests, as well as by the increase in absentee ownership resulting from growing corporate concentration. In response to inquiries about profit levels and the amount of revenue raised by nursing homes in charging residents for non-insurable services, we were informed that the Ministry of Health did not require this information from nursing home operators. This experience is consistent with earlier attempts to obtain similar information. In 1977, Baum observed that:

> "While the [1975 interministerial study on institutional care] makes clear what government is spending and what homes are receiving [from government,] what is not made clear is just how the money is being used. And it seems that the government has no intention of informing the public how those monies are used. More particularly, government will not release even generalized data about profit

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8. Concerned Friends of Ontario Citizens in Care Facilities, Op. Cit., p. 26.
9. Liberal Policy Research Office, "Options for Living: Directions for Change", Research Document, Liberal Party of Ontario, June 1984, p. 8.
10. Ibid.
11. Concerned Friends of Ontario Citizens in Care Facilities, Op. Cit., p. 30.

> levels of nursing homes - profits obtained entirely from taxpayers' money. In response to an enquiry from the Ontario ombudsman concerning profits, the deputy minister of health wrote of the need to maintain secrecy in the interest of nursing homes."[12]

In light of the fact that government contributions to nursing homes amounted to over $241 million in 1983/84, this secrecy is difficult to justify. This point was also stressed by the Concerned Friends of Ontario Citizens in Care Facilities in their 1982 brief to the Minister of Health:

> "... In spite of ... the total reliance on public funds and payments made by individuals, these homes are accountable to neither the public nor individual consumers of their services, nor it would seem, to government."[13]

Homes for the Aged, by contrast, have considerably more community input and control which help to ensure accountability. Charitable homes have community boards of directors, while the municipal homes have elected officials represented on their committees of management.[14]

It is fair to say that the Ministry of Health appears to recognize that accountability to service users and to government is a major problem in nursing homes. At the time of writing, new initiatives are being considered which may include some of the needed changes. As well, the Ministry now requires that nursing homes establish a residents' association which

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12. Baum, Op. Cit., p. 81.
13. Concerned Friends of Ontario Citizens in Care Facilities, Op. Cit., pp. 80-81.
14. Nicholas Manherz, "Response to 'Canada Bracing for a Tidal Wave'", Ontario Association of Homes for the Aged, 1981, p. 3.

would hear complaints from residents, although it would lack power to take action.[15]

In a speech to the ONHA, Keith Norton, the Minister of Health reminded nursing home operators that:

> "... the confidence of the public is the bedrock on which your industry is built. This public trust is your most valuable asset and no effort should be spared to protect it."[16]

In the same speech Mr. Norton described the measures the Ministry is taking to ensure greater accountability, including: the introduction of legislation to broaden the grounds for ministerial intervention leading to revocation of a licence or Ministry take-over; and the availability of full public inspection reports on nursing homes.[17] While these are clearly steps in the right direction, it is questionable whether they will afford adequate protection to the many vulnerable people living in nursing homes. The fact that the Minister also stressed in his speech that "the government believes strongly in self-regulation in your industry"[18] should make one cautious about becoming too optimistic. As demonstrated in the United States, self-regulation appears to be imcompatible with high quality of care in nursing homes.

Day Care Centres and Children's Residences

Problems related to accountability in the commercial day care and children's residential services fields are not yet well documented. Information is largely anecdotal. Although there do appear to be issues related to accountability to service users and government, they are not of the

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15. Jean Gadd, "Get Residents Involved, Nursing Homes are Told", The Globe and Mail, September 23, 1983.
16. Remarks by the Hon. Keith Norton, Minister of Health, to the Ontario Nursing Home Association, Toronto, Ontario, September 22, 1983.
17. Ibid., pp. 8-11.
18. Ibid., p. 11.

magnitude of those encountered in nursing homes. There are several reasons for this. First, neither day care centres nor children's residences in Ontario are dominated by large corporate chains. Although there are some chain-owned operations where absentee ownership may be a problem, most commercial day care centres and children's residences are small, mom-and-pop operations where the owners run the program. It should be recalled from the earlier review of American literature that the most serious shortcomings in both day care centres and nursing homes were related to chain ownership.

Second, although the commercial sector's role is substantial, it does not presently control the day care and children's residential services fields. In the nursing home industry, it appears that severe accountability problems have arisen as a result of constant demand, a lack of alternatives, and virtually no competition.

These observations should not, however, be interpreted to mean that day care centres and children's residences are problem-free with respect to accountability. In commercial day care, a major issue is the lack of parent involvement in the running of the centre. Day care centres operated by community boards and parent co-ops, by contrast, ensure a high degree of parent participation, usually considered an essential ingredient in providing a high quality of care and promoting accountability. When one considers that over half of all pre-school children enrolled full-time and almost two-thirds of all infants are served by commercial centres, the lack of parent participation does indeed seem to be a serious problem.

The field of children's residential services has historically been plagued by problems of fragmentation, lack of coordination, irrational and inconsistent funding mechanisms, and lack of accountability.[19] Recent attempts to improve accountability include legislative changes such as the development of residential standards, and the establishment of grievance procedures for children in residential care. In addition, there have been several Ministerial re-organizations and reviews of funding mechanisms designed to rationalize and coordinate service provision. It remains to

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19. See, for example, Central Toronto Youth Services, Priorities, The Effects of Funding Structures on Services to Adolescents in Ontario, 1976.

be seen, however, whether these changes can be effectively implemented and whether they will result in higher quality and more accountable services for their child residents.

Ensuring accountability to government has been particularly elusive for COMSOC because of the heavy reliance on contracting with non-governmental organizations. Many children's residences, particularly the for-profit homes, do not even deal directly with the Ministry; their services are purchased by Children's Aid Societies which are responsible for the care offered to CAS wards. This practice of CAS's contracting out for residential care may have an impact on accountability to government. Our investigations revealed that the Ministry keeps no central record of how many and which residences are operated for profit and cannot estimate how much provincial money is being spent to subsidize commercial services. Information on scope and trends, therefore, was difficult to obtain. This lack of information is not merely inconvenient; it raises questions about COMSOC's ability to monitor adequately the service system for which it is ultimately responsible. The changes introduced in Bill 77 which would allow any approved agency, including commercial organizations, to provide children's services necessitate that the Ministry have abundant information on the scope and performance of for-profit agencies.

Although COMSOC officials were unable to supply us with detailed data, a spokesman for the Children's Aid Society of Metro Toronto did provide some impressionistic information. The Metro Toronto CAS, which relies heavily on for-profit residences for outside placement of children, cites quality control, accountability and stability as serious problems in the commercial sector.[20]

The Metro Toronto CAS would prefer placing children in non-profit homes which, through their community boards, seek higher levels of accountability and service quality. Because for-profit residences do not have this safeguard, the potential for problems is felt to be greater than in non-profit residences.

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20. Information obtained from Robert Fulton, Manager of Outside Resource Placements, Metro Toronto Children's Aid Society, April 1984.

Another problem related to the use of the commercial sector, according to the Metro Toronto CAS's perspective, is the high "corporate death" rate among for-profit children's residences. An annual turnover of 30 percent negatively affects the quality of services available to children by preventing continuity of care and stability, and impeding attempts at planning. In addition, such high turnover places the CAS in the position of continually having to scramble to secure new resources.[21]

Rest Homes/Retirement Homes and Boarding Homes

In the rest home/retirement home and boarding home industries the accountability problems associated with proprietary care are exacerbated by the lack of provincial regulation. Both provincial opposition parties have recently called for legislation governing the operation of rest homes.[22] Metro Toronto's Gerstein report on discharged psychiatric patients makes similar recommendations regarding boarding homes.[23]

Although rest homes and boarding homes generally receive no direct provincial governnment funding, many of their residents pay for their accommodation with welfare cheques or other forms of government subsidies. Therefore, indirectly, a substantial amount of taxpayers' money is going to these unregulated homes. More important, considerations of quality of service and accountability to residents require there to be greater provincial government intervention in the rest home and boarding home industries. Increasingly, municipal governments are having to bear the burden of regulation. According to Metro Toronto's 1979 report on adult residential facilities:

> "Local municipalities are ... forced to fund the regulation of boarding houses which fill the vacuum caused by lack of alternative community-based residential care facilities. Regional municipalities must pick up the slack in providing links

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21. Ibid.

22. See: The NDP's "Aging With Dignity", Op. Cit., p. 24; and the Liberals' "Options for Living: Directions for Change", Op. Cit., p. 5.

23. Gerstein, Op. Cit., p. 9.

> between health and social services. Unfortunately, the sufferers are the vulnerable elderly persons, the patient discharged from psychiatric facilities and the community which is inadequately prepared to deal with them."[24]

5.2 Influence on Public Policy

Nursing Homes

Ontario nursing homes, both individually and collectively, have persistently sought recognition from the provincial government; sustained lobbying by the Ontario Nursing Home Association has been successful in attaining high visibility and substantial influence.[25] The ONHA acknowledged the relative success of its contact with government in a communications audit undertaken by Argyle Communications which noted:

> "... an extremely high level of awareness of the role and purpose of nursing homes within appointive and elective ranks of the Government of Ontario. It is evident that individual nursing homes have made their presence known to the MPPs and to the Ministry of Health over the years, and that the Ontario Nursing Home Association has reinforced these contacts with a comprehensive and sustained degree of lobbying and liaison."[26]

The audit also suggested a concern on the part of nursing home operators that the government may be tempted "to move essential services out

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24. Municipality of Metropolitan Toronto, Adult Residential Facilities, Op. Cit., p. 20.
25. Individual nursing home operators have reciprocated by showing their support for the Conservative Party. See, for example: "Nursing Home Gifts to Tory Party Assialed", The Globe and Mail, December 7, 1983.
26. Communications Audit for the Ontario Nursing Home Association, prepared by Argyle Communications, Inc., October 5, 1982, p. 8.

of the private sector and into the public sector."[27] Such concerns would appear to be groundless. Given the provincial government's support of private enterprise and the capital costs of such an undertaking, public takeover of private nursing homes is extremely unlikely.

Arguing that the current funding system offers no incentive to provide high quality of care, the ONHA has consistently lobbied for higher per diem rates or a different form of funding. In a thinly veiled threat to the Ministry of Health, the ONHA points out that inadequate funding may cause one of two occurrences:

- "the quality of care may have to be compromised in order to balance the equation between funding and costs; or
- the private sector may withdraw from the provision of nursing home services, thereby causing government involvement in the provision of capital funding for these services in some manner."[28]

Such threats recall the point raised earlier that, when control of the market sets in, the regulated begin establishing the conditions for their own regulation. The threat to compromise service quality or to withdraw services is being used by the ONHA to achieve a more attractive and profitable funding formula. According to the ONHA, such a formula should be based on a "more explicit cost-based method with differentials for size, amount of care provided, and owner's equity."[29] Several methods of altering funding are proposed, including giving owners a specific return on investment and calculating a percentage of costs as profit.[30] At the time of writing, the Ministry is reviewing the funding formula and jurisdictional

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27. Ibid., p. 8.
28. Report on the Role of Nursing Homes and a Fair and Equitable Funding Methodology, Op. Cit., p. 28.
29. Ibid., p. 8. (Emphasis added).
30. Ibid., p. E4-E6.

matters pertaining to nursing homes. An announcement is expected in the fall of 1984.

Day Care and Children's Residences

The for-profit children's residences have not organized themselves into a provincial lobby organization, although there have been some efforts to influence public policy. Commercial day care centres, on the other hand, are represented by the Association of Day Care Operators of Ontario (ADCO). Consistent with the actions of its American counterparts, ADCO opposed provincial standards which would result in an increase in costs for centres. Specifically, in a 1982 brief to the Ministry of Community and Social Services, ADCO took exception to proposals to reduce group size and child/staff ratios, arguing that additional costs would be incurred and, moreover, that "there is no data to indicate the current legislation does not provide safe, stimulating, quality care for children."[31] The non-profit sector, by contrast, encouraged the development and acceptance of the new standards.[32]

ADCO's brief did not restrict itself to commenting on the proposed standards. Supporting the concept of residual welfare, it advocated minimal government involvement in all aspects of day care. Included under the heading, "Political Concerns", was the observation that:

> "Free, universal day care is not required or financially feasible. Many families can afford and take pride in paying for their day care. To shift the entire onus of responsibility from the family to the government, would make child-raising an irresponsible commitment and involve little or no planning on the part of the family."[33]

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31. Association of Day Care Operators of Ontario, "Day Care: The Commercial Sector's Point of View", August 1982, p. 2.
32. Action Day Care, Newsletter, March 1984, p. 7.
33. Association of Day Care Operators of Ontario, Op. Cit., p. 6.

Pressure from the commercial day care lobby is believed by many observers to have contributed to the lowering of minimum day care standards in Ontario in 1974.[34]

5.3 Quality of Service

Nursing Homes

Serious concerns about the quality of care and adequacy of staff training in nursing homes were recently raised in a report written on behalf of the Canadian Medical Association. In discussing possible solutions to the accommodation problems of elderly people, the Task Force on the Allocation of Health Care Resources observed that:

> "When an institution becomes the only answer for the care of an elderly person, it must be one that is run on a principle of loving care, not one of tender, loving greed ... In a comparison between old age homes run for profit and those run by non-profit ethnic or religious organizations, it is the latter that often exhibit a higher standard of care, food, rehabilitation, innovative recreational programs, and at the end of life, compassion, palliative care and respect for the individual."[35]

The Task Force acknowledges that the enforcement of strict standards in nursing homes, although important, would act as only a short-term solution to current problems. The following recommendation is offered as

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34. Novick, "Social Policy: The Search for a Provincial Framework", Op. Cit., p. 386.

35. Task Force on the Allocation of Health Care Resources, Health, A Need for Redirection, Canadian Medical Association, August 1984, p. 36.

a 'permanent solution':

> "... that all jurisdictions move as quickly as possible towards the elimination of 'care for profit' institutions and establish non-profit facilities ... The vast bulk of the accommodation should be an integral part of a publicly financed and operated program. In this way, both the sufficiency and the quality of accommodation for Canada's elderly will be better guaranteed."[36]

The above concerns are reinforced by the fact that both nursing homes and rest homes have in recent months been the subject of coroners' inquests into the deaths of residents.[37] According to information received from the coroner's office, there were 174 "unnatural deaths" in nursing homes in 1983, compared with only 47 in charitable and municipal Homes for the Aged.[38] There are approximately the same number of residents in the two types of facilities. While it is obviously impossible to draw conclusions from these statistics without more information, this data, in combination with the recent inquests and numerous reports of violations of the Nursing Homes Act, do raise serious questions about the quality of care in some nursing homes.

Several 1983 verdicts of the coroner's inquests into nursing home and rest home deaths addressed the issue of inadequate government regulation and assessment of facilities. In addition, concern was frequently expressed over inadequate staffing and staff training in nursing homes.[39] The Concerned Friends of Ontario Citizens in Care Facilities have also pointed out that there

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36. Ibid., pp. 36-37.

37. See, for example: "Rest Homes Licenses Sought by Inquest", Cambridge Daily Reporter, March 2, 1983; "Nursing Home Staff, Procedures Criticized at Coroner's Inquest", The Globe and Mail, October 7, 1983; "That Wasn't Just Another Nursing Home Death", The Toronto Star, October 23, 1983.

38. Information obtained from the Chief Coroner of Ontario, Ministry of the Solicitor General, July 1984.

39. See, for example, the Verdicts of Coroner's Jury, dated March 17, 1983; October 7, 1983, September 23, 1983; and January 22, 1983.

are major shortcomings in the legislation pertaining to nursing homes which jeopardize quality of care. In particular:

- o there is no definition of nursing care and the minimum care level is far too low (most people requiring only 1½ hours of nursing care would be far better served in the community);
- o the over-emphasis on structural aspects of nursing homes and non-care related issues, such as records and procedures, ignores quality of care aspects; and
- o even when nursing care is mentioned, the emphasis is only on physical care.[40]

In addition to the problems occasioned by weaknesses in the legislation, many nursing homes have been found to be in violation of the Act. Recent reports and media stories have drawn attention to the scope and magnitude of these violations, which include: health and safety hazards resulting from poor maintenance, unauthorized administering of drugs, and shortages of bed linen, face cloths and towels.[41] Frequent complaints by nursing home residents or their relatives to the Concerned Friends of Ontario Citizens in Care Facilities include complaints related to under-staffing and poorly qualified staff, lack of stimulation, inadequate food, physical environment, and medical care.[42]

Rest Homes/Retirement Homes

There appears to be a tremendous range in the quality of care offered by rest homes/retirement homes. The more luxurious homes which

40. Concerned Friends of Ontario Citizens in Care Facilities, Op. Cit.,p. 55.
41. See, for example: "Nursing homes flout law: Rae", The Globe and Mail, November 22, 1983.
42. Concerned Friends of Ontario Citizens in Care Facilities, "Evaluation Sheets", for the period from August 1 to October 31, 1983.

cater to well-to-do elderly residents who can afford to pay up to $3,000 a month are reported to provide very good services. Yet, the concern has been raised that some of the swanker homes are becoming "bootleg nursing homes" which provide medical care without supervision and operate under no provincial regulations.[43]

The most serious criticisms of the rest home industry have, however, been directed at the homes which serve low-income people with special needs. According to a recent research report, such rest homes suffer from a variety of problems including: a random mixture of ex-psychiatric patients, people with alcohol problems, handicapped persons, and elderly residents; a lack of programs to involve or stimulate residents; and dirty and unsanitary conditions.[44] Similar conditions in boarding homes have been documented in a number of reports over the last several years.[45]

Day Care Centres

The quality of care offered by commercial centres is the subject of considerable debate. In the absence of comparative studies of service quality in day care centres, information is largely anecdotal and impressionistic. It is fair to say, however, that many experts from the day care community in Ontario and the rest of Canada feel that service quality is generally better in non-profit centres than in commercial centres.[46] This view has, of course, been reinforced by the commercial sector's opposition to improved standards and its frequent disputes with labour. The feeling is that, because day care is not a large profit-generating service, what

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43. See, for example: Report of the NDP Caucus Task Force, Aging with Dig-Dignity, Op. Cit., p. 24; and "Playing for Time", The Globe and Mail, Op. Cit.

44. Aging with Dignity, Op. Cit, pp. 24-25.

45. See, for example: The Association of Municipalities of Ontario, "Housing for the Psychiatrically Impaired", AMO Reports 62, November 1981; Gerstein, Op. Cit.; and Municipality of Metropolitan Toronto, Adult Residential Facilities, Op. Cit.

46. See, for example: Pat Schulz, "Who Cares for Our Children?" in Patti Schom-Moffatt, and Cynthia Telfer (eds.), The Women's Workbook, Between the Lines (Toronto 1983), p. 44; and Action Day Care, Newsletter, March 1984, p. 7.

profits there are must be made at the expense of service quality and staff salaries. Examples abound of cost-cutting measures in commercial centres which affect quality of care, such as using teaching and administrative staff to perform maintenance and kitchen duties, thereby reducing child-staff ratios at various times during the day.[47]

A survey of 321 Metro Toronto day care centres conducted by the Social Planning Council in March 1984, revealed that commercial centres had considerably fewer names on waiting lists and had far more vacancies than non-profit centres (see Table 3 in the Appendix). This suggests that commercial centres may not be as popular with parents, possibly because of concerns over quality of care.

5.4 Flexibility and Responsiveness to Need

A trait for which the commercial sector is sometimes acclaimed is the ability to respond quickly and flexibly to identified demand - or, at least, to opportunity. For-profit organizations have won this reputation, in part, through their ability to market their services effectively. Anxious for government contracts, commercial companies appear to be particularly adept at mobilizing their resources to respond to calls for tenders. Whether this enthusiasm and responsiveness can be sustained and whether the result is a high quality of service are the concerns raised by the critics of commercial service provision.

There is evidence in Ontario that for-profit organizations respond more flexibly than do many voluntary agencies. From a funder's perspective, this flexibility is important in deciding who should be awarded a contract. For example, commercial homemaking agencies are often favoured because they are prepared to offer services in two-hour blocks, while some voluntary organizations will offer nothing less than four hours of service.[48]

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47. Arthur Ross, "Corporate Day Care", in Good Day Care, Fighting for It, Getting It, Keeping It, Kathleen G. Ross (ed.), The Women's Educational Press (Toronto: 1978), p. 94.

48. Conversations with policy officials, Metro Toronto Community Services Department and Ministry of Health, April and June, 1984.

Some commercial agencies are prepared to absorb financial losses which might result from charging less than non-profit organizations or providing more flexible service. A number of the commercial homemaking agencies operating in Ontario, for example, are owned by large companies who can afford to employ a "loss leader" strategy to enter the market. The fear, of course, is that once they corner the market they will raise their prices and become less responsive to service needs. There is evidence that this has occurred in Alberta where, after an 18-month contract with the Home Care Program, the commercial nursing agencies raised their prices to exceed those of the voluntary agencies.[49]

In the day care field, the commercial sector has pioneered the provision of day care to infants, a service for which there is a great demand and less involvement by voluntary organizations and virtually none by municipal day care centres.[50] Even though infant day care is more costly to provide (and thus has generally been avoided by voluntary organizations) many commercial centres have developed infant programs. This practice not only helps commercial centres compete for fee-paying parents and secure full enrollment, but also it offers possible long term advantages. It is expected that the children will remain in the same centre when they 'graduate' from the infant program, thus providing 'ready-made' clientele for the more profitable pre-schoolers' programs.

Finally, many for-profit children's residences, unlike their non-profit counterparts, appear to have admission criteria which enable agencies, such as CAS's, to place virtually any child. Since commercial residences receive no government funding for operating costs, they are dependent on the per diem amount paid for each resident. The flexible admission criteria of many commercial residences stem, in part, from a desire to keep beds filled. While convenient for placement agencies, this practice may not

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49. Touche Ross & Partners, "Response to Issues Raised re: Cost Efficiency Alternatives for Home Care Service Delivery", Calgary, October 28, 1983.

50. Ministry of Community and Social Services, Day Care Policy: Background Paper, Op. Cit.

always be in the best interests of the children being admitted since the appropriateness of the particular placement may be only a secondary consideration.

For many commercial organizations, the apparent gains in flexibility and responsiveness have been achieved at the expense of staff salaries and questionable labour practices. In the three above-mentioned service areas - homemaking, day care, and children's residences - all of which offer poorly paid jobs in the first place, the salaries in the commercial organizations are lower than in their voluntary and public counterparts. In day care, for example, average salaries in Metro Toronto are estimated to be $13,180 for municipal centres, $11,400 for non-profit, and $10,000 for commercial centres.[51] Similar discrepancies were found to exist in some children's residences by the operational review undertaken by COMSOC in 1979.[52] Further, a 1982 study of homemaking services in Canada found that the starting wage for a full-time homemaker was lowest in the commercial agencies.[53]

In nursing homes and Homes for the Aged, there appears to be little difference between the wages paid in the commercial and non-profit sectors. Although unionization has come about more slowly in nursing homes than in Homes for the Aged, the level of unionization is now approximately the same - 60 percent.[54] However, nursing homes have recently begun laying off unionized health care aides and other staff and replacing them with non-unionized workers at half the wages.[55] It should be noted that the Ontario Labour Relations Board recently ruled against a Scarborough nursing home which fired 92 health care aides and warned employers "... that they cannot

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51. Estimates based on 1979 figures from a study by Action Day Care and the Social Planning Council of Metro Toronto, plus $2,000.

52. Peter Turner, Operational Review, Children's and Youth Institutions, Ministry of Community and Social Services, 1979.

53. Canadian Council on Homemaker Services, Op. Cit., p. 47.

54. Information obtained from the Ontario Association of Homes for the Aged and the Ontario Nursing Home Association, August 1984.

55. See: "92 Nursing Home Aides Lose Jobs to Outside Firm", The Toronto Star, November 16, 1983; and "Union Takes Action to Topple Employer Over Back Pay Bill", The Globe and Mail, December 15, 1983.

get rid of unionized workers who perform tasks central to the purpose of the company, simply to save money."[56]

Concerns stemming from low private sector salaries and poor labour practices relate not only to worker exploitation but also to the quality of services provided. It is not surprising to learn from studies that those organizations offering the lowest salaries employ the least qualified personnel and experience high levels of staff turnover. Under such conditions, concerns about the quality and continuity of care cannot be avoided.

5.5 Equality of Access and Equity

The most common interpretation of 'equity' in human services is 'equality of access'. Restrictions to access include financial, geographic, ethnic, or educational barriers.[57] Equality of access is implied by the notion that people should have a right to services, based solely on their needs.

The impact on access of for-profit service provision is difficult to assess since equality of access to many human services is not guaranteed in Ontario. In all three sectors, access may be limited because of the existence of user fees, restrictive eligibility criteria, or the inequitable geographic distribution of services. Nevertheless, there are indications that existing access problems may be exacerbated by the trend to commercialization.

It is widely held that nursing homes are reluctant to accept

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56. "Nursing Aides Can't be Fired, Board Rules", The Globe and Mail, July 20, 1984.

57. Pranlal Manga and Geoffrey R. Weller, "The Failure of the Equity Objective in Health: A Comparative Analysis of Canada, Britain, and the United States", Comparative Social Research, Vol. 3, 1980, p. 230.

residents who require heavy care.[58] Many of these people apparently end up in Homes for the Aged, particularly in municipal homes, where the Ministry of Community and Social Services contributes to the cost.[59] The Ministry of Health conducted a small study in 1983 to determine whether there were in fact differences in the level of care required by residents in nursing homes and Homes for the Aged. Unfortunately, the Ministry does not intend to release its findings. Conclusive evidence concerning some of the alleged differences between nursing homes and Homes for the Aged is therefore not available. It should be recalled, however, that the former Minister of Health acknowledged the commercial nursing homes' "built-in preference" for residents requiring little care (p. 19).

There are also financial barriers to access in the nursing home industry. Although the Ministry of Health sets the daily rate which homes are allowed to charge residents for extended care, most nursing homes charge residents for an array of services which are not covered either under OHIP or the resident co-payment fee. Uninsured services include laundering of personal clothing, transportation, special social activities, hairdressing, telephone and adult diapers. The Ministry of Health exercises no control over these additional charges; nursing homes are free to set their own rates.[60] The Ministry has no record of how much revenue is raised by nursing homes from these additional charges. In Homes for the Aged, on the other hand, most of these services are provided at no charge to residents.

In addition, nursing home residents who require more than one-and-a-half hours of nursing care may, if they can afford it, hire an outside private nurse or attendant. According to the Concerned Friends of Ontario Citizens in Care Facilities,

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58. This observation was also made in an April 1983 Verdict of the Coroner's July: "At present, heavy care patients ... are not accepted by nursing homes, preference being given to light care patients."

59. Ontario Association of Homes for the Aged, Op. Cit., p. 3.

60. Information obtained from the Ministry of Health, April 1984.

> "Nursing homes have embarked on a new method of extorting additional funds from vulnerable clients in the form of "private nursing" care. Veiled threats accompany the suggestion that the family obtain private nurses, as references are made to the resident 'requiring too much care' ..."[61]

In order to estimate the extent of this practice, the Social Planning Council telephoned 12 commercial nursing registries to inquire into which types of facilities nurses were being sent. More than half of the agencies reported that they frequently sent private nurses to nursing homes, where the service was always paid for by the resident. Only one agency indicated that it assigned nurses to residents in Homes for the Aged; in this instance the home, not the resident, paid for the service.

In day care, there is less scope for charging more than parents are willing to pay. Although day care is largely a marketplace service, charges to parents are controlled in two ways: day care centres are not allowed to charge more for fee-paying parents than for subsidized parents (this amount is set by the municipality), and competition with private sitters holds down costs.

As noted earlier in the review of the American literature, commercial homemaking agencies in the U.S. tend not to locate in under-serviced areas. This is consistent with the pattern in Ontario as well, where the commercial homemaking organizations are more likely to exist in the large, urban areas. In addition to geographic barriers, access may also be restricted by the cost of service. With funding from the United Way, some non-profit nursing and homemaking agencies have been able to develop sliding-fee scales to permit access by persons unable to pay the full fee and who are not covered by a government subsidy.[62] Their commercial counterparts, by contrast, serve only those who can afford to pay for the service or for whom the government or a private insurance company pays.

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61. Concerned Friends of Ontario Citizens in Care Facilities, Op. Cit. p.43.
62. For example, the Victorian Order of Nurses and Visiting Homemakers of Metro Toronto.

6.0 CONCLUSION AND RECOMMENDATIONS

Ontario's drift to commercialization of human services is proceeding by both design and default. In the absence of an overall provincial policy, the extent of commercialization varies from one service field to another and from one ministry to another. The Ministry of Health seems to favour delegating responsibility to the commercial sector, while the Ministry of Community and Social Services has in the past maintained a more cautious approach. However, recent changes to the legislation governing COMSOC's children services appear to invite the expansion of commercial programs.

What has developed in Ontario is a patchwork quilt of provincial government policies with no clearly-articulated, coherent rationale to link the disparate elements. Although the practices of the two ministries may not always be consistent, the thread of commercialization runs through their policies. The trend toward greater reliance on the commercial sector is becoming obvious, particularly in the more profitable health services. However, the available evidence we have gathered from Ontario and the United States raises serious questions about the development of human services for profit. These fall into the following categories: 1) accountability/ influence on public policy; 2) quality of service; 3) equity/equality of access; and 4) cost-effectiveness.

Accountability /Influence on Public Policy

The problem of accountability in the human services is a difficult one, and yet it strikes at the heart of the democratic process. Proponents of commercialization argue that existing government regulations plus the discipline of the free market system are sufficient to hold commercial organizations accountable. Yet, in the United States there is evidence that the day care industry "managed to delay the implementation of new federal day care regulations", while in the nursing home industry, "anti-regulatory sentiment and organized lobbying have been even more pronounced." (p. 58)

In Ontario, continuing complaints about the lack of accountability of nursing home operators have led the Ministry of Health to introduce legislation to broaden the grounds for ministerial intervention. Further, accountability in the nursing home industry is obscured "by the lack of information regarding ownership and financial interests as well as by the increase in absentee ownership ..." (p. 84) In Ontario's commercial day care centres, a major accountability issue is the lack of parent involvement. (p. 87)

Despite the fact that it is the Ontario taxpayer who shoulders the cost, information about the revenue or profit levels of commercial human services is not available to the public. The Ministry of Community and Social Services keeps no central records of how many and which children's residences are operated for profit. (p.88) Commercial rest homes/retirement homes operate under no provincial regulations. (p.89)

Quality of Service

Although actual research studies are rare, anecdotal evidence suggests that quality of care suffers in many for-profit services. In the United States, commercial day care centres pay their staff notoriously low wages, resulting in high staff turnover and poor staff morale. (p. 69) In Ontario, there are examples of cost-cutting measures which negatively affect service quality in commercial centres. (p. 97)

The most serious concerns about service quality have been raised in connection with nursing homes. In Ontario, recent coroner's inquests and reported violations of the legislation have identified inadequate staffing and staff training, health and safety hazards, and unauthorized administering of drugs as problems. (p. 95) In the early 1970's a U.S. Senate Subcommittee concluded that half of America's nursing homes were so sub-standard that they were life threatening. (p. 72) More recently, commercial ownership was found to be over-represented in the worst quality of care cases. (p. 72)

Equality of Access/Equity

It is usually assumed that human services should be open to all who qualify; once in the system, all people should receive the same level of care, based on their different needs. Yet "the most serious charge against the proprietary health care industry, particularly the for-profit hospitals, is that they engage in cream skimming and dumping". (p. 74) This practice inevitably leads to a two-tiered system of health care, with access severely limited to those unable to pay. Ontario's former Minister of Health has reinforced this concern by observing that "... a profit motivated system appears to have a built-in preference for patients who need the least attention." (p. 19) Although conclusive evidence is not available, it is widely held that nursing homes in Ontario refuse to accept residents who require heavy care. (p. 100)

Cost Effectiveness

Proponents of commercialization claim that competition leads to lower costs and greater efficiency. Yet, recent studies examining the relative costs in for-profit and non-profit hospitals in the United States all showed that "both costs to patients and operating expenses were higher in for-profit hospitals (p. 63) and that the for-profit hospital chains achieved neither overall operating efficiencies nor economies of scale in administrative or fiscal services.(p. 64)

In the nursing home industry, there is evidence that lower costs in the for-profit homes may have been achieved at the expense of quality of care and workers' salaries.(p. 65)

Proponents claim that commercial services are highly sensitive to public pressure and respond better than other forms of delivery. Yet, there is little to indicate that commercial human services have any commitment to a community other than their commitment to make a profit. If for some reason the source of profits should run dry, one could expect a with-

drawal of services. The Ontario Nursing Home Association has already threatened to do this if a more favourable funding formula is not granted. (p. 91)

Finally, "it may be neither efficient nor rational for a government to subsidize the for-profit sector" at a time when resources are scarce and social spending is being restrained.(p. 19) A concern for cost-effectiveness must include consideration of the quality of service and profit levels in commercial organizations, as well as an assessment of overall operating efficiency.

These are only a few of the many concerns which have been raised in this exploratory report. However, the situation is serious enough for us to recommend that the provincial government take immediate action on these issues. The recommendations which follow are directed primarily at the Government of Ontario because the provision of human services falls within the provincial government's jurisdiction. However, because municipal governments may also have a substantial impact on commercialization in certain program areas, two recommendations are aimed specifically at the Municipality of Metropolitan Toronto.

To the Government of Ontario, we recommend:

1. That there be a moratorium on commercialization of human services in Ontario until an appropriate review has been undertaken. This moratorium would entail:

   - o no new licensing or funding of commercial operations;
   - o no further approval of experiments in hospital management by for-profit firms;
   - o no decisions to allow the commercial sector to enter new service fields (e.g. prisons); and
   - o no legislative or policy shifts which may result in the expansion of thecommercial sector (e.g. retain present statutory restrictions on for-profit service provision

when enacting Bill 77, the Child and Family Services Act).

2. That the Standing Committee on Social Development of the Ontario Legislature immediately undertake a policy review of commercialization in Ontario which would include answers to the following questions:

- o How should commercial service provision be defined? (e.g. should it include mom-and-pop operations, as well as corporate chains? should questionable "non-profit" activities be included?)
- o What is the extent of publicly-subsidized commercial service provision in Ontario?
- o What should be the criteria for determining if and when commercial service provision is desirable and appropriate in particular program fields?
- o What role, if any, should the commercial sector play in Ontario's human services (e.g. provider, funder, management consultant?)
- o Are there any human services which should not be provided by commercial organizations?
- o Should there be provincially-enforceable restrictions on commercial service provision on the basis of factors such as: chain ownership; absentee ownership; percentage control of the market; corporate concentration; profit levels; geographic concentration; and the vulnerability of service users?
- o If there is to be commercial provision of certain services, what mechanisms/protections are required to ensure: equal access to services; accountability to the government, the public, and service users; high quality of service; full disclosure of information, including profit levels and ownership?

3. That the outcome of the review be a statement of the provincial

government's policy on and future plans for commercial service provision.

4. That the policy review be an open and public process which would allow sufficient time for public hearings and presentations.

5. That, as an interim measure while the policy review is being conducted, the provincial government take immediate steps to improve accountability, access to services and to information, and monitoring of quality of care in all services currently provided by commercial operators. These steps would include:

   - o the introduction and enforcement of clear and measureable standards of quality of service;
   - o full public access to all inspection reports and complaints investigations;
   - o full public access to organizations' financial reports and ownership information;
   - o access by service users to an independent advocate or grievance procedure;
   - o provincial regulation and inspection of rest homes/retirement homes and boarding homes;
   - o the introduction of a mechanism to ensure equal access to nursing homes, regardless of financial circumstances and level of care needed.

To the Municipality of Metropolitan Toronto, we recommend:

6. That the Municipality of Metropolitan Toronto immediately evaluate the quality of services provided by commercial day care centres and homemaking agencies, and that there be a public report on the findings.

7. That no new purchase-of-service contracts be awarded to commercial agencies until the evaluation has been completed.

APPENDIX

TABLE 1

NUMBER OF MUNICIPAL AND CHARITABLE HOMES FOR THE AGED AND APPROVED BED CAPACITY, EXTENDED CARE AND RESIDENTIAL CARE, ONTARIO, 1973 TO 1983/84

	MUNICIPAL			CHARITABLE		
	No. of Homes	Extended Care Beds	Residential Care Beds	No. of Homes	Extended Care Beds	Residential Care Beds
1973[1]	87	9,815	7,589	88	2,431	6,207
1975	88	9,776	7,918	90	2,447	6,403
1977	90	10,066	8,318	94	2,728	6,915
1979/80[2]	89	10,210	7,857	93	2,873	7,092
1981/82	89	10,201	7,856	92	2,678	7,007
1983/84	89	10,301	7,756	93	2,803	7,106
INCREASE OR DECREASE	2	486 (5%)	- 167 (-2.2%)	5	372 (15.3%)	899 (14.5%)

1. Based on calendar year from 1973 to 1977
2. Based on fiscal year from 1979/80 to 1983/84

Source: Ministry of Community and Social Services, June 1984.

TABLE 2

CHANGES IN PROPORTIONATE CONTRIBUTIONS TO REVENUE,
NURSING HOMES AND HOMES FOR THE AGED, EXTENDED CARE,
ONTARIO, 1972/73 TO 1982/83

	NURSING HOMES[1]		HOMES FOR THE AGED[2,3]		
	Provincial Gov't Portion	Resident Portion	Provincial Gov't Portion	Resident Portion	Municipality or Charitable Corporation
1972/73	72.0%	28.0%	69.4%	23.4%	7.2%
1974/75	67.9%	32.1%	NA	NA	NA
1976/77	63.8%	39.3%	64.2%	26.0%	9.8%
1978/79	64.7%	35.3%	NA	NA	NA
1980/81	60.7%	39.3%	59.7%	27.8%	12.5%
1982/83	65.2%	34.8%	62.7%	30.5%	6.8%
PERCENTAGE INCREASE OR DECREASE	-9.4%	23.6%	-9.7%	30.3%	-5.5%

1. Based on per diem rates
2. Based on actual contributions
3. Data prior to 1980 and all data for municipal Homes for the Aged based on calendar year

Sources: Ministry of Community and Social Services, February 1984, and Ministry of Health, April 1984.

TABLE 3

LICENSED CAPACITY IN DAY CARE CENTRES,
NUMBER ON WAITING LISTS
AND NUMBER OF VACANCIES, BY OPERATOR TYPE,[1]
METRO TORONTO, MARCH 1984

Operator Type	Licensed Capacity	Number on Waiting List	Number of Vacancies	Vacancies as a percentage of Capacity
Municipal	2,540 (15.5%)	219 (5.5%)	125 (7.2%)	4.9%
Non-Profit	6,480 (39.5%)	3,097 (77.2%)	450 (26.1%)	6.9%
Commercial	7,380 (45.0%)	696 (17.3%)	1,150 (66.7%)	15.6%
TOTALS	16,400 (100%)	4,012 (100%)	1,725 (100%)	10.5%

1. Based on a telephone survey of 321 day care centres in Metro Toronto offering full-time care to pre-school children.

Source: Social Planning Council of Metropolitan Toronto, March 1984.